# WASHINGTON STATE PLANNING GRANT
# ON
# ACCESS TO HEALTH INSURANCE

## EXCERPTS FROM 2005 PROPOSALS FOR ADDITIONAL FUNDING

Submitted to:

HRSA Grants Application Center (GAC)
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In Response to:

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Submitted by:

Washington State Office of Financial Management

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**Making Health Care Work for Everyone**

# Washington State Planning Grant on Access to Health Insurance

## Excerpts from Proposals for Limited Competition Pilot Grant and Limited Competition Planning Grant

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## 1. PROJECT ABSTRACT SUMMARY - LIMITED COMPETITION PILOT AND LIMITED COMPETITION PLANNING GRANT PROPOSALS[1]

**Project Title: Access to Health Insurance Project, Washington State**

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**Background**: Over the years, Washington has done quite well in tackling access to coverage. However, in 2004 our uninsured rates began to increase and look a lot like mid-to-late 90's rates. For adults, the turning point occurred around 2000. The story for children isn't quite so regressive, but the change seen in 2004, compared to 2002, is still disheartening.[2]

We have experienced over a decade of slowly declining employer-based coverage (71% in 1993 to 66% in 2004[3]). Over much of the same period there has been a steady increase in coverage via public programs (9% in 1993 to 19% in 2002; back to around 17.5% in 2004). In fact, much of our earlier decrease in uninsured rates was due to public program expansions – notably Medicaid for children and Basic Health for adults. Nonetheless, public program growth hasn't kept pace with employer coverage decline.

Historically (1980s and 1990s), Washington was a leader on many coverage fronts – expansion of coverage for low-income working (Basic Health) and for children and their families (Medicaid coverage for children up to 200% federal poverty before SCHIP); pre HIPAA market reforms; early adoption of a high risk pool; sweeping health care reform to achieve universal coverage (subsequently repealed); dedication of tobacco litigation dollars to health care (with an emphasis on prevention).

As we moved into the new century, declines in employer-based coverage were joined by declines in public programs – immigrant children were moved from Medicaid to Basic Health and did not re-enroll as hoped, Basic Health coverage slots were decreased and funded by dollars intended (via a citizen's initiative) for expansion, and Medicaid administrative changes resulted in much larger than anticipated exits of children. However, there also have been a few recent "incremental" bright spots including coverage for the working disabled, opening Basic Health to people eligible for Trade Act coverage, resolving an individual market collapse, and reforms to the small group market to address affordability. In addition, our newly elected Governor has proposed an 05-07 biennial budget that delays implementation of premiums and restores 12-month continuous eligibility for some Medicaid children, restores state-funded health coverage for immigrant children, retains Basic Health coverage at 100,000 individuals, and shores up the no-insurance safety net by preserving state grants to community clinics and increasing Medicaid reimbursement rates for hospitals.

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[1] The goals of the Pilot and Planning Grant projects are the same. The difference between the two proposals is the degree to which the State Planning Grant program can contribute to meeting these goals given the smaller amount of Planning money compared to Pilot money that is potentially available.

[2] The uninsured rate for adults bottomed in 2000 at 10.0%, rising to 13.2% in 2004. The uninsured rate for children in 2004 was 6.0%, up from an all time low of 4.5% in 2002.

[3] This may seem like a small percentage drop but when applied to a large base results in substantial numbers of people.

**Proposed Project**: In line with concerns about declining employer coverage (and implications for public programs and costs), one of two coverage issues[4] around which there is consensus is that it is getting more and more difficult for Washington's small employers to offer and their employees/families to purchase affordable, predictable health insurance coverage. Thus, we are requesting Limited Competition Pilot or Planning funds from the State Planning Grant (SPG) program to provide expert technical assistance to Washington to design a small business assistance program. The focus of the program is a small employer purchasing pool; a component of the program is premium assistance to help low-income families buy-into employer coverage. There are three issues that need simultaneous attention if we are to make any inroads for small employers and their employees: (1) affordability of base level premiums, (2) yearly growth and volatility of premiums, and (3) range of options that respond to employer/employee needs. We will draw on lessons from (1) Washington's experience with Basic Health as one of the nation's original 3-share programs (employer/sponsor, employee/enrollee, state), (2) experience of other states that have implemented small employer pools and assistance programs, and (3) expert researchers who have evaluated the characteristics of successful versus less successful implementations.

The broad goals of the Pilot program are to (1) develop a viable, sustainable underwriting pool of employees/families of small businesses, (2) design premium assistance strategies including use of individually-based subsidies paid in a group coverage environment, (3) test ideas around benefit packages based on best evidence (whether traditional or part of the newer consumer-directed movement), risk management mechanisms such as health-based risk adjustment and reinsurance as a potential for "buying down" the price of insurance (a type of implicit subsidy), and use of community organizations to put a local face on the program (to meet the preference of small employers to "buy locally"), (4) develop the specifics of a plan to seek federal matching funds on a non-Medicaid program (via a HIFA waiver), and (5) attempt a pool governance structure that is joint public / private with an option for transition of workable ideas to the private market. An issue to be addressed is whether the Pilot will be statewide or initially tested in several communities. The Pilot is about more than creating 1-2-3 new benefit designs; it's about creating an environment for sustainable, affordable coverage.

Washington's recently elected Governor is committed to helping small employers purchase affordable health coverage. In 2005, she introduced legislation to do so and is working with the Chairs of the House and Senate health care committees to find solutions. A best guess is that there are some 150,000 uninsured employees (and their dependents) of small business – a substantial portion of whom (around 40%) are low-income or work in micro firms of less than ten employees where affordability issues are most acute. This 150,000 represents about one-quarter of Washington's uninsured. The specific target population for this program is a subset of the 150,000 uninsured workers/families associated with small business – it is the roughly 112,000 that are *full-time*.

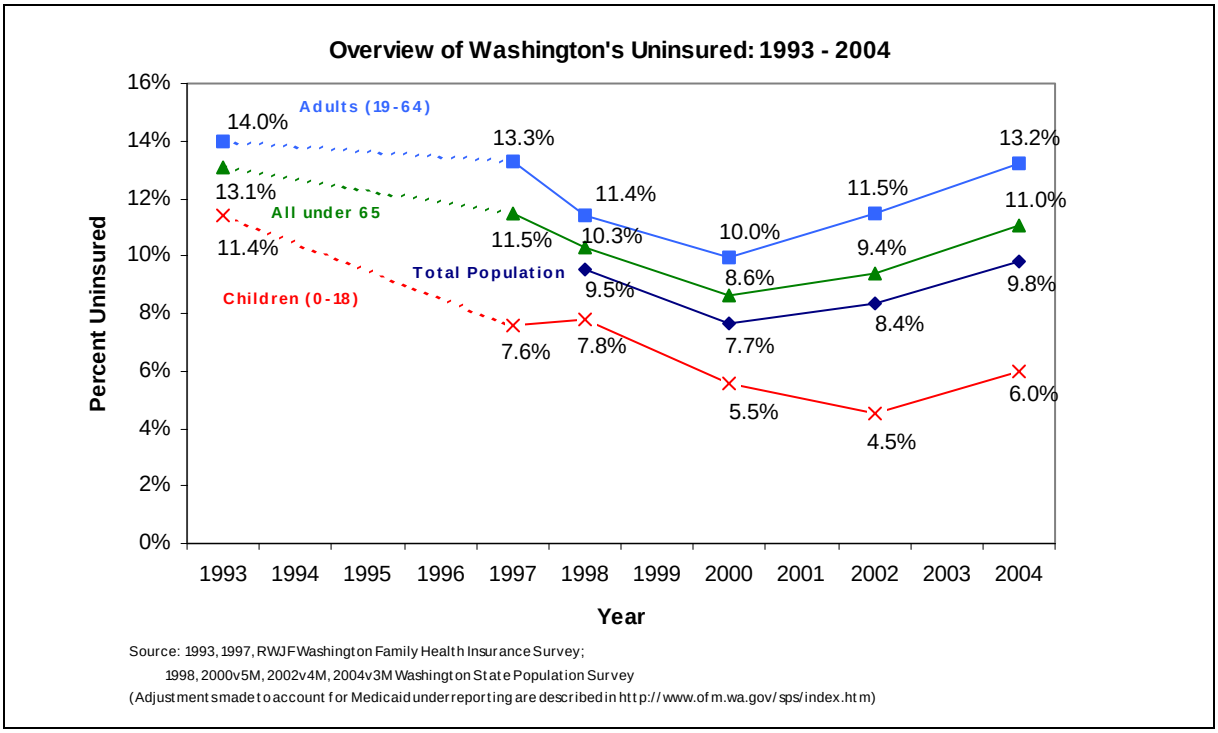
SPG dollars will be used to support specific design activities that are not covered by state allocated funding, with the goal of producing a higher quality program than otherwise would be possible.

[4] Covering all children by 2010-11 is the second issue around which there is general agreement; although the specific approaches for doing so are uncertain.

# 2. PROGRAM NARRATIVE

## a. CURRENT STATUS OF HEALTH INSURANCE COVERAGE

Washington State has long been a national leader in providing health care coverage to its residents, emphasizing incremental steps that target low-income populations through affordable public programs. However, in recent years Washington has been losing ground. The current status of health insurance coverage is a story with five enduring messages: (1) rates of uninsurance appear to be increasing among all age groups, (2) characteristics and key health issues of the uninsured remain consistent, (3) fiscal deficits continue with no end in sight, (4) the delivery system faces growing challenges in providing care for the uninsured, and (5) the insurance market appears unable to offer affordable coverage to many small employers.

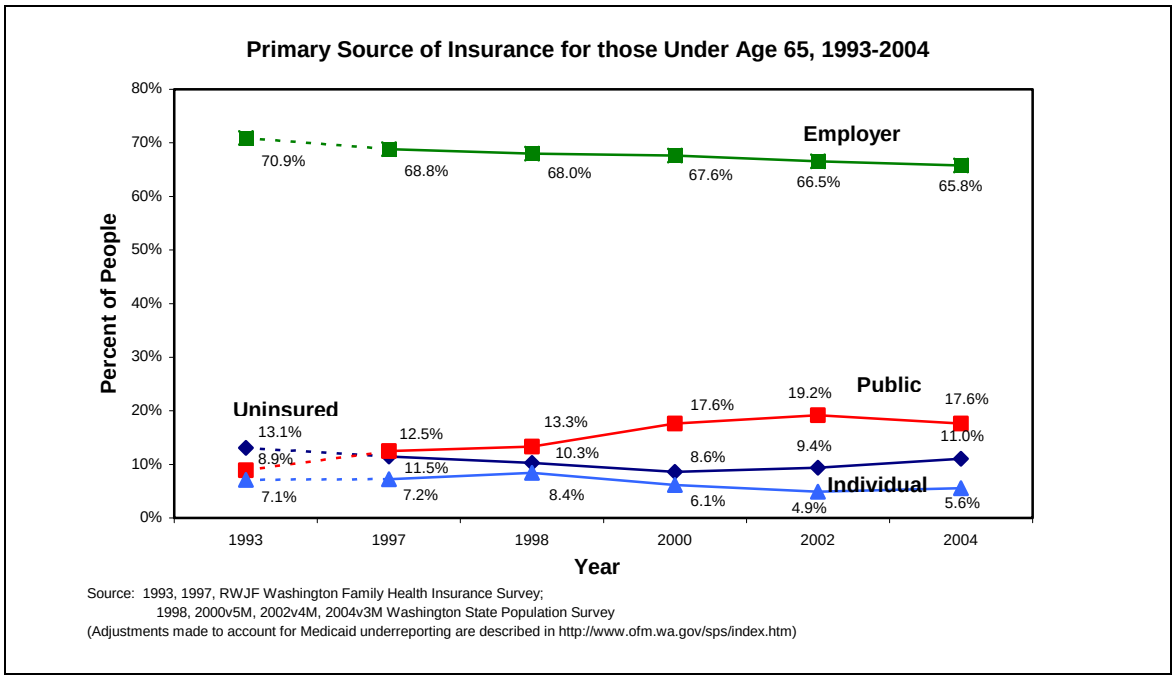



### (1) Rates of Uninsurance are Increasing

In the 1980's and 1990's Washington was a leader on many coverage fronts – expansion of coverage for low-income working families (Basic Health) and for children and their families (Medicaid coverage for children up to 200% federal poverty before SCHIP); pre HIPAA market reforms; early adoption of a high risk pool; sweeping health care reform to achieve universal coverage (subsequently repealed); dedication of tobacco litigation dollars to health care (with an emphasis on prevention). Coverage steadily increased.

More recently, Washington has been losing ground. The uninsured rate for the total population increased from 8.4% in 2002 to 9.8% in 2004[5] (i.e., from about 506,000 to almost 606,000 individuals). Over 99% of these individuals are under age 65. The rate of uninsurance also appears to be increasing for all age groups.

[5] Uninsurance rates are based on information collected by Washington State's biennial household survey. They include adjustments that account for Medicaid underreporting common in population surveys and therefore differ from rates derived from national surveys that do not include the adjustment.




For those that do have coverage, the trend seems to be a decline in access via employers coupled with a rise in access through public programs. For the **under age 65 group**, coverage via an employer has slowly but steadily dropped from 70.9% in 1993 to 65.8% in 2004. Over the same period, coverage via public programs (Medicaid and Basic Health) has almost doubled, increasing from 8.9% in 1993 to 17.6% in 2004, a slight drop from the 2002 rate of 19.2%. But, public program expansions have not been able to keep pace with declines in the employer-based (and individual) markets. The devil is in the details – although access via employers *appears* to have changed rather modestly over time, at least until 2002 it has been the primary driver of the increasing uninsurance rate simply because so many of Washington's residents traditionally gained access to health insurance via an employer. If employer coverage had continued in 2004 at the same levels as in 1993, an additional 280,000 individuals would have been covered via an employer. Even more striking is that if public coverage had continued at 1993 levels, close to 480,000 more individuals would *not* have coverage today.

**(2) Characteristics and Key Issues of the Uninsured Remain Consistent**

Although rates of uninsurance have varied over time, the profile of Washington's uninsured has remained consistent and mirrors the story conveyed by national surveys for most states and the nation. For the under age 65 uninsured population, Washington's 2004 story is that:

- Over 70% are **members of working families** (at 2000 levels, a little over ¼ are connected to small employers, about 1/3 are self-employed, and the rest are connected to large employers). *Current and precise characteristics of these employer connections represent an important data gap we continue to work towards filling.*
- Almost 62% are **members of families that earn less than 200% of federal poverty** (with family income up to $37,700 for a family of four in 2004, this group continues to have the greatest risk of being uninsured).
- Almost 40% are members of working families and also low-income.
- About 45% are **adults without dependent children**, however, the combination of the economic downturn and its unemployment, public program changes, and declining

employer-based coverage has resulted in families with children becoming an increasingly larger portion of the uninsured, close to 40%.

- Adults are now more than 5 times as likely to be uninsured as children. Close to 44% are **young adults age 19-34** while only 16% are children under age 19.
- There continue to be major disparities in rates of uninsurance for more **rural regions** of the state compared to more urban regions, and for **racial and ethnic minorities**, American Indians / Alaskan Natives and Hispanics. However, these disparities are decreasing as more attention to preventive care is emphasized in efforts consistent with the Healthy People 2010 initiatives. *Standard issues affecting reliability and comparability of race and ethnicity data continue – finding solutions to these data gaps would be helpful even though the fundamental message remains consistent.*
- The proportion of uninsured workers employed in large firms (with 50 or more employees) has been steadily growing since the late 1980's[6]. However, in 2002 8 out of every 9 jobs in firms that do not offer health coverage are in **small firms employing 50 or fewer workers** (and more than half are in "micro" firms with fewer than 10 employees)[7].

The key reasons Washingtonians continue to give for not having health insurance (consistent with national surveys) are that:

- Insurance is unaffordable. Overwhelmingly this is the reason given for not having health insurance. In Washington, many families cannot afford to buy private coverage unless their incomes are above 250% of federal poverty. Applicants in Washington's individual market must pass a health screen. Many of those who do not pass and are referred to the state's high-risk pool do not follow-through because it's too costly (even for those with some subsidy assistance).
- Their employer doesn't offer insurance. In some cases the employer offers coverage but the individual is ineligible (e.g., may be part-time, seasonal, hasn't worked for the company long enough, or dependent coverage isn't offered).

The key health issues facing the uninsured population come as no surprise – as national and state data show, lack of insurance means that people "live sicker and die earlier" than would be the case if insured. They delay or do without preventive, diagnostic and other treatment services. In 2002, over 25% of uninsured individuals were unable to get needed medical care due to cost, "(i)n fact, over 300 people die in Washington State every year due to … no health insurance coverage" [8]. Many studies[9] show that lack of insurance coverage negatively affects access to care among low-income children in particular. Uninsured but Medicaid-eligible children are twice as likely as those enrolled in Medicaid to have an unmet medical need and to have not seen a doctor.

**(3) Fiscal Deficits Continue**

Washington State faced a FY2003-2005 biennial budget gap of $2.7 billion in a budget of $23 billion. As in many states, this gap occurred primarily as a result of slower than expected revenue growth related to the recession; growing public program caseloads (i.e., Medicaid, Basic Health and SCHIP) and corresponding health care cost increases; increases in higher education

[6] Glied, S. 2003. The Growing Share of Uninsured Employed by Large Firms. *The Commonwealth Fund.*
[7] Data from the MEPS 2002 survey.
[8] Crittenden, B. & Neumeister, A. *RISKY BUSINESS: Working People Losing Health Coverage*. Working for Health Coalition, June 2004.
[9] Dubay, L., et al. 2001. Covering Parents through Medicaid and SCHIP: Potential Benefits to Low-Income Parents and Children. *Urban Institute.*

enrollment; a growing prison population; and ballot initiatives that required increased teacher salaries and reduced classroom sizes in the K-12 education system (subsequently not funded.) In response to this budget crisis, the 2003 and 2004 budgets directed that "a number of steps be taken to reduce the growth in spending on low-income medical assistance".[10] These included eligibility limitations, increased cost sharing, and benefit cuts described in section b, *Earlier Efforts to Reduce Uninsured*.

Some of these changes contributed to the increased numbers of uninsured apparent in the 2004 State Population Survey. However, we do not yet have complete data to understand their full impacts on program participation, uninsured numbers, the broad health care system, or on the health status of the clients themselves. In spite of some technical limitations, a survey of the impacts on Basic Health enrollees indicated that many people who left the program were uninsured, although changes in program exit rates and risk pool make-up could not be directly linked to the premium and cost sharing changes. SPG staff are currently assisting the Medicaid program with analysis of a survey (currently in the field) of individuals who left the program after eligibility policy changes began in April 2003. *Our proposed grant activities continue technical assistance to public programs to help fill gaps in our knowledge about individuals who leave public coverage.*

On the heels of four years of tough budgetary decisions by the governor and legislators, it is clear that our fiscal issues are not over. Although the March 2005 Revenue Collection Report[11] notes that "(r)evenue surged in the most recent month due to strong consumer and business spending and a still red-hot real estate market", figures estimate a potential $2.2 billion dollar budget shortfall for 2005-07 in a growing budget of $26 billion. This comes with an increasing gap between revenue and expenditures in the Health Services Account (the source of funding for many of Washington's public coverage programs) as medical costs grow at 10% per year. "Savings" from cuts and efficiencies proposed by Governor Locke in his December 2004 budget, just prior to leaving office, are being down-sized as the current Legislature and Governor Gregoire write their 2005-2007 budgets. Without additional revenues, further cuts in Basic Health eligibility, elimination of routine and preventive adult dental care, reduction in grants to community clinics, and reduction in graduate medical education payments to key Washington hospitals, are options that have been suggested to limit public program expenditures. To successfully expand access to health insurance in this fiscal climate we will need opportunities to shore up employer coverage via private mechanisms and private/public partnerships.

**(4) Delivery System Faces Growing Challenges in Serving the Uninsured**

Studies of Washington's safety net *before* the full impact of the recession and subsequent rising unemployment levels (ranking Washington 2nd in the nation) indicated that the capacity to serve the uninsured in Washington was strong.[12] "The cuts in Medicaid and (Basic Health) could … have long term effects. The wide-ranging cuts in provider reimbursement rates will likely affect beneficiaries' access to care. Rate cutbacks also raise questions about the financial viability of many institutions, especially safety net hospitals. Owing to the eligibility and outreach changes, states will likely see a rise in the uninsured." Analysis from the 2004 State Population Survey

[10] Testimony by fiscal staff, Senate Ways and Means Committee hearing, February 9, 2005.

[11] March 10, 2005 Revenue Collection Report to the Executive and Legislative branch from the state's chief economist, Chang Mook Sohn, the Executive Director of the Economic and Revenue Forecast Council.

[12] Long, S.H. & Marquis, M.S. (1999). Geographic Variation in Physician Visits for Uninsured Children: The Role of the Safety Net. *Journal of American Medical Association,* 281 (21), 2035-2040.
Holahan, J. & Spillman, B. (January 2002). Health Care Access for Uninsured Adults: A Strong Safety Net is Not the Same as Insurance. *New Federalism, Series B, No B-42.* The Urban Institute.

shows this to be so. Access to care through this increasingly fragile system is highly concerning, as it is throughout the nation. For example:

- Reports from hospitals and community health centers indicate that levels of uncompensated care provided are increasing. Preliminary estimates of uncompensated care provided by hospitals in 2003 indicate that charity care may have increased an additional 75% and bad debt 48%.[13] (Washington State statute requires hospitals to provide care for emergency conditions, provide "charity care" for those persons with family incomes below federal poverty, and use sliding scales discounts from charges for those persons with income between 100-200% of federal poverty.)
- From a survey of their clients, community health centers reported a 50% increase in the number who were UNinsured between January 2002 and December 2003[14] while the number who were INsured rose by only 10%. Community health centers in Washington are slightly more dependent on the fate of public insurance programs than centers nationwide because they have organized as a health insurance plan and have become one of the key Medicaid and Basic Health program service providers as indicated in the following table.

**INSURANCE STATUS OF COMMUNITY HEALTH CENTER PATIENTS**

| BPHC Community Health Centers | Washington State[15] | Nationwide[16] |
|---|---|---|
| Patients uninsured | 34% | 39% |
| Patients insured by Medicaid/SCHIP | 40% | 36% |
| Other Public insurance (e.g., Basic Health, Medicare) | 15% | 9% |
| Private Insurance | 11% | 15% |

Over half of their clients are working (57%); over half of these employed full-time, nearly 1/3 employed part-time and the remainder employed in seasonal or temporary jobs.

- Hospital emergency room (ER) doctors are also reporting growing numbers of uninsured individuals seeking non-emergent care through the ER. Fiscal year end reports to the Department of Health indicate that ER volume has increased 30% since 1999, primarily in urban hospitals.
- Providers have been affected by the managed care reforms of the 1990's, by controls in Medicaid reimbursement rates and by continuing escalation of malpractice insurance rates. The Washington State Hospital Association reports that hospitals are charging "other payers" over 120% of costs to makeup for public program shortfalls. In 2000, Washington ranked 31st in the nation in its Medicaid reimbursement of fee-for-service providers.[17] Washington's malpractice problems have created access issues for both insured and uninsured, with access to specialty care of greatest concern. Conventional wisdom, but with little concrete evidence to support it, is that malpractice costs are driving doctors from the state (and if not from the

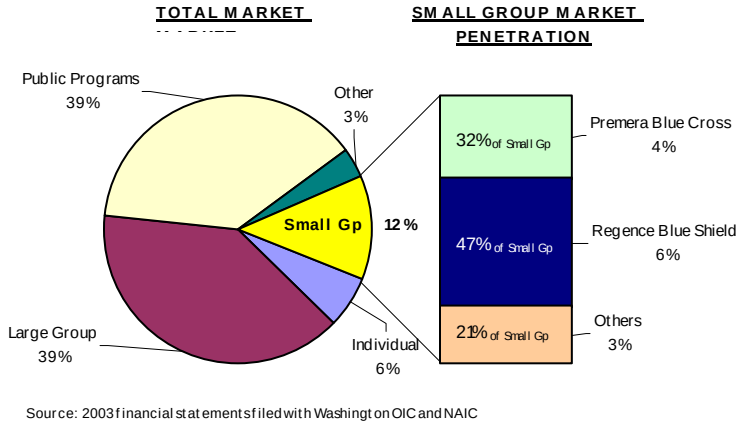
[13] Washington State Department of Health, *hospTrends*, July 2004.
[14] Kavoussi, K. & Burchfield, E. *Stretching the SafetyNet: The Rising Uninsured at Washington's Community Health Centers.* May 2004.
[15] Bureau of Primary Health Care: State Summary for Washington for 2001. Users by Socioeconomic Characteristics.
[16] Sara Rosenbaum, Peter Shin, Julie Darnell. Economic Stress and the Safety Net: A Health Center Update. June 2004. Kaiser Commission on Medicaid and the Uninsured.
[17] Testimony by Medical Assistance staff, Senate Ways and Means Committee hearing, February 9, 2005.

state at least from high risk specialties). *Gaps in comprehensive data to confirm and fully understand these behavior patterns are considerable.*

**(5) The insurance market appears unable to offer affordable coverage to many small employers**.

Within the employer-based coverage market, Washington law distinguishes between small employers (groups of 2-50) and large employers (groups larger than 50.) Individuals not provided coverage through an employer have an opportunity to purchase health insurance through the individual market, in which 8% with the highest health risk are screened into a high-risk pool. Three major carriers, Premera Blue Cross, Regence Blue Shield, and Group Health, provide coverage for over 80% of the total market[18]. To be successful, any options that propose to increase coverage of Washington's uninsured through the private market require the support of these "big three" carriers.

**2003 Washington State's Private Insurance Carriers' Small Group Market**
**(Total enrollment of 354,000 with total premium of approximately $910 million)**




Source: 2003 financial statements filed with Washington OIC and NAIC

For the small group market in particular, which represents just over 12% of the market (enrollment and premium), close to 80% is split between two carriers, Regence Blue Shield (47%) and Premera Blue Cross (32%). Several carriers share the remaining portion (e.g., Asuris Northwest, Kaiser Foundation, Group Health Cooperative, Aetna, KPS).

Close to half the small group market serves workers in the construction, retail-trade, health care / social assistance, and accommodation and food service industries services[19]. It serves about 60% of the construction industry, 30% of retail trade, 40% of accommodation and food services, and 27% of health care / social assistance services. These are also the industries in which we find low-wage workers and the lowest rates of offer in Washington.

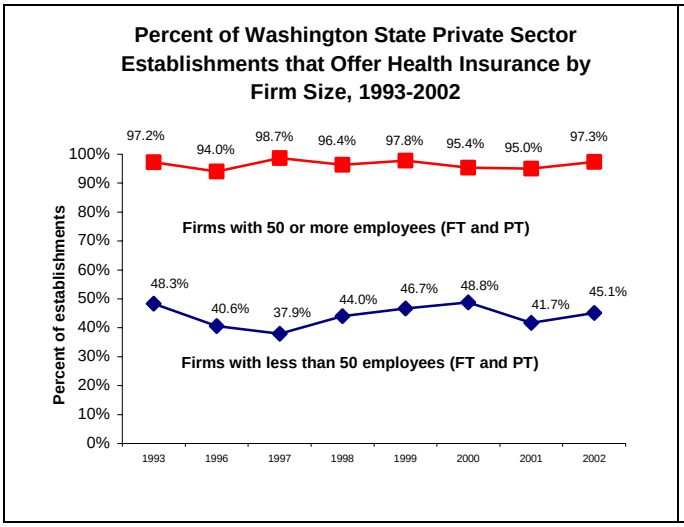
Although Washington's health insurance market works well for many groups and individuals in the state, the high level and volatility of premiums create barriers for small groups seeking private insurance coverage[20]. While virtually all large employers have offered health insurance

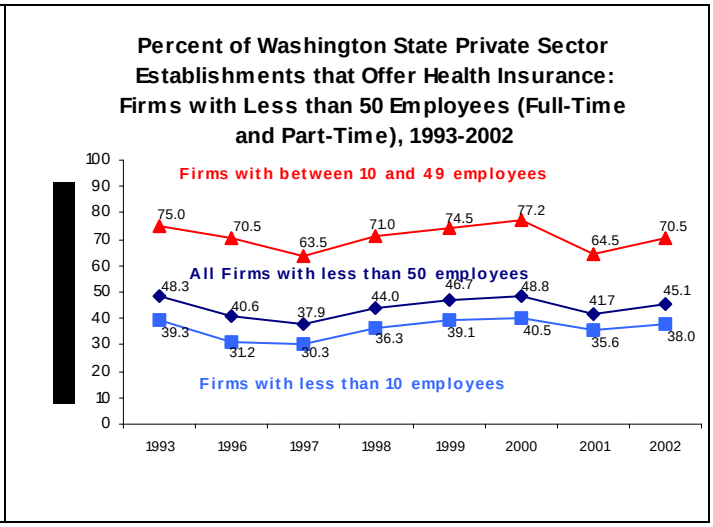
[18] Managed care penetration (i.e., HMO penetration) in the state, taken from the 2003 Kaiser Family Foundation state health facts is 13.1%, ranking the state at 31 in the nation. HMO enrollment (approximately 804,000 enrollees) includes enrollees in both traditional HMOs and HMO point-of-service plans through: group/commercial carriers, Medicare, Medicaid, FEHBP, direct pay plans and unidentified HMO products.

[19] Office of the Insurance Commissioner, Washington State Small Group Insurance Statistics, 2003.

[20] Watts, C., et al. Pooling and Reinsurance in Washington state Health Insurance Markets: Review of the OIC Proposal. February 25, 2005.

since 1993, less than half of all small employers have been able to do so. But, among small employers averages don't tell the full story - firms with between 10 and 49 employees have consistently been much more likely than the "micro" firms with less than 10 employees to offer coverage. And, regardless of firm size, eligibility, take-up, and coverage rates are quite similar among workers in firms that do offer coverage.




In comparison with large firms, small firms have consistently experienced greater increases in insurance premiums since 1989, and greater variability in increases each year[21]. Their premiums buy fewer benefits with higher cost-sharing that varies more from firm to firm. Their administrative costs are higher and their risk pools more unstable as a result of greater cycling in and out of the market, employee turnover, and firm failure[22]. These factors drive carriers' concerns about unpredictable risk and consequently impact premiums and benefit designs.

Insurance products in this market are therefore becoming increasingly costly, prompting small employers (redefined during the 2004 Legislative session to groups of 2-50 employees) to shift costs to their employees or drop coverage altogether. For small firms that do not currently offer coverage, especially those small firms with low-wage workers, employer-sponsored coverage is simply unaffordable. It is likely that our recession has exacerbated these patterns but data that allow extensive evaluation of local trends in the small group market (and in the large group market) are incomplete.

For small firms that do offer we know a lot about some aspects of employer coverage, but there are many other aspects where data are sparse. For example, we know there is a big difference between "single" coverage purchase rates by employees of small vs. large firms, but we don't know if that leaves family members of small firms' employees uninsured, or if they are covered through other means.[23] *Providing technical assistance to fill these data gaps will be an important component of our proposed grant data analysis activities.*

[21] Gabel, J., et al. 2004. Risky Business: When Mom and Pop Buy Health Insurance for their Employees. *The Commonwealth Fund.*

[22] Lee, J. 2002. Are Health Insurance Premiums Higher for Small Firms? *The Synthesis Project. Robert Wood Johnson Foundation.*

[23] 67% of insured workers in the smallest firms (with less than 10 employees) purchase "single" coverage while only 41% of insured workers in the largest firms (with 1000 or more employees) purchase "single" coverage

## b. EARLIER EFFORTS TO REDUCE THE NUMBER OF UNINSURED RESIDENTS

A 2002 assessment of health policy for low-income people in Washington noted that Washington has been a leader in health reform beginning with a major legislative package passed in 1993.[24] That package included employer and individual mandates, expansion of Medicaid coverage for low-income children, extended home and community based coverage for the elderly and disabled, major reforms of the individual and small-group insurance markets, and expanded enrollment of the state's Basic Health[25] program.

While many of the health reform components were repealed by the Legislature in subsequent years, major public program expansions continued and were very successful. By 2002, nearly 96% of the state's children were insured. These expansion efforts built upon the Medicaid and Basic Health programs, targeting (1) uninterrupted coverage for low-income children ages 0-18, (2) affordable public / private pooling for low-income working adults, and (3) family unity by coordinating coverage for children and adults across programs. Notable successes include:

- A series of incremental Medicaid innovations that promoted uninterrupted coverage for low-income children ages 0-18 by expanding eligibility for Children's Medicaid to 200% of federal poverty and by implementing SCHIP coverage for children between 200 and 250% of federal poverty.
- In addition, Medicaid initiated a small premium assistance program to fund private coverage for Medicaid-eligible adults, primarily dual-eligibles.
- Basic Health expanded as a state subsidized pool emphasizing affordable coverage for low-income working adults, that incorporates enrollee premium contributions based on a sliding scale and point-of-service co-payments. It has become a nationally recognized "ready laboratory" for assessing the impacts of health policy options on low-income families.
- Basic Health and Medicaid developed seamless coordination of coverage to support family unity for low-income families, enrolling children in Medicaid (Basic Health Plus) and their parents in Basic Health.
- Basic Health implemented an employer-sponsored insurance program, offering individual coverage to employers as a group. This has met with limited success but emphasizes that where the private sector has struggled to stabilize the small group market, Basic Health offers a foundation for controlled experimentation on new ideas to support small employers.

Between Medicaid and Basic Health, approximately 958,900 residents, (i.e., 16% of all state residents), including 538,000 (i.e., 33%) children were covered in July 2001. At the same time that employer-based coverage rates were declining, Washington's overall insured rates were increasing due in no small part to public programs, as noted – at least up until 2002.

The following charts provide an overview of programs for children and adults by income eligibility.

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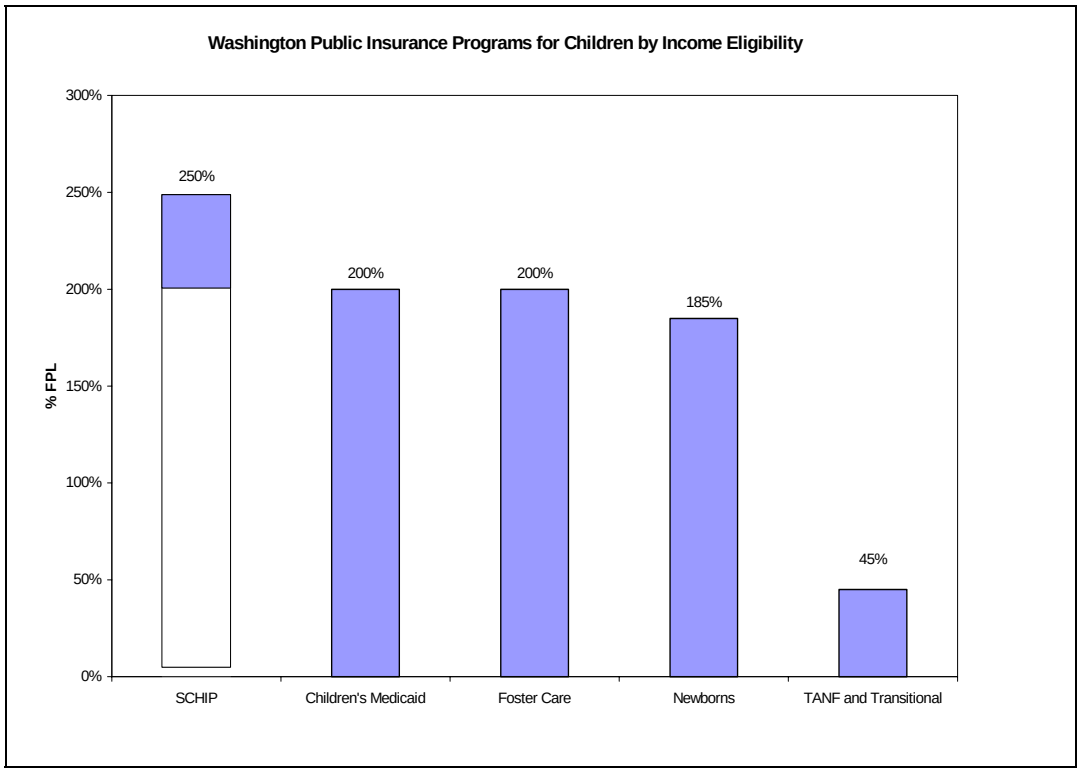
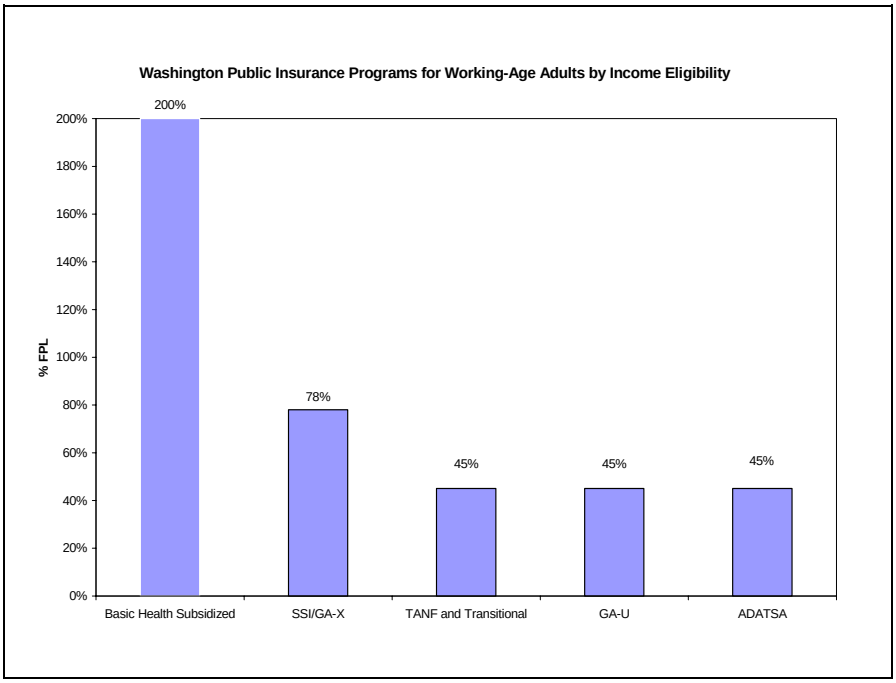
[24] Holahan, John and Mary Beth Pohl. "Recent Changes in Health Policy for Low-Income People in Washington." Assessing the New Federalism, State Update No. 24, February 2002. Washington D.C.: *The Urban Institute.*

[25] Basic Health is a state-only funded program for low-income working individuals. It contracts with private health plans and provides subsidized coverage, using an income-based sliding scale, to people at and below 200% of federal poverty, not eligible for Medicare, and not institutionalized at the time of enrollment. (There are a few nuances to these eligibility rules, such as for homecare workers, but the above cover the main criteria.)




An array of programs is available for children from ages through 18, with family incomes up to 250 percent of federal poverty.

Public insurance options are also available for working age adults with family incomes up to 200 percent of federal poverty, however most programs target only the lowest income adults with a disability or children.




Washington's more recent history, beginning with the 2001-03 biennium, vis-à-vis public programs is a little different. The nexus of our progressive social policy and our conservative fiscal policy (coupled with the economic downturn) have produced a "health system for low-income individuals [that] seems to be in a fairly fragile state".[26] People are losing coverage and rates of uninsurance are increasing as already noted. In the 2003 and 2004 legislative sessions, during the throes of one of the longest recessions and deepest budget deficits in recent

[26] Holahan, John and Mary Beth Pohl. "Recent Changes in Health Policy for Low-Income People in Washington." Assessing the New Federalism, State Update No. 24, February 2002. Washington D.C.: *The Urban Institute.*

Washington history, difficult policy and budget decisions were made to reduce the growth in spending on public programs through eligibility limitations, increased cost sharing, and benefit cuts. These included:

- Moving immigrant children from Medicaid to Basic Health, but re-enrollment in Basic Health did not occur at the level hoped.
- Replacing the state funded Medical Assistance Medically Indigent program (which helped pay hospitals for uncompensated care) with lidded grants (i.e., Disproportionate Share, DSH, payments distributed by a formula based on uncompensated care)
- Redesigning the Basic Health program to meet the Legislature's mandate of an 18% reduction[27]. The resulting much changed benefit design was implemented in January 2004. In addition to increases in premium-sharing and co-payments, with which Basic Health enrollees were already familiar, enrollees faced deductibles, co-insurance, and out-of-pocket maximums, all new aspects of the Basic Health design. Alongside these changes enrollment was reduced from 125,000 to 100,000, with imposition of a waiting list.
- Reduction in the scope of Medicaid adult dental coverage by 25%.

In the midst of the bad news there have been some incremental "bright spots" for public programs.

- Basic Health opened as a "qualified" plan to allow people access to Trade Act coverage, although take-up has been modest, consistent with the national trend.
- Coverage for the working disabled.
- The 2004 Legislative budget authorized a $10 per-month premium to be implemented July 2004 for Medicaid categorically needy-optional children in households with incomes between 151% and 200% of federal poverty (mandatory children in this income range would not be subject to premiums). Governor Locke postponed the implementation until July 2005. Governor Gregoire's proposed budget for the 05-07 biennium delays implementation of premiums still further, "to ensure that more than 19,000 children in our state will have access to health coverage". This is consistent with her health care platform that emphasizes a goal of covering all children under age 18 by the year 2010-11.
- Increased administrative requirements for continuing Medicaid eligibility (e.g., new signature and income verification requirements, adoption of a 6-month eligibility review cycle, and termination of 12-month continuous eligibility) resulted in much larger than anticipated exits of children. Governor Gregoire's proposed budget restores 12-month continuous eligibility for some Medicaid children.
- Her proposed budget also restores state-funded health coverage for immigrant children and shores up the no-insurance safety-net by preserving state grants to community clinics and increasing Medicaid reimbursement rates to hospitals.

In addition to its struggles with sustaining public program coverage, Washington also has a recent history with problem-ridden individual and small group insurance markets. For example, the individual market literally collapsed in 1998-99 – you could not buy individual coverage in Washington – and did not re-open until 2000-01 following Legislative action that in part allowed health underwriting to return. More recently, the small group market has been the focus of attention. Although it did not collapse in the same way as the individual market, the warning signals were clear. Lively debates on how to solve the market's "premium affordability" problems occurred in 2003 with strong philosophical differences that make it difficult to find common ground on solutions. However, formal avenues other than Legislative and initiative processes where public

[27] The Legislature's specific directive was to reduce by 18% the actuarial value of the Basic Health design.

policy on covering the uninsured can be debated, remain very limited.[28] Discussions continued into 2004 and resulted in Legislative action that was the final bill to pass before the session ended. Key steps taken to support the small group market redefined small employers from 1-50 employees to 2-50 employees; authorized carriers to offer limited health plans with a limited schedule of benefits; and further modified community rating laws to allow premiums to vary more widely than previously allowed based on risk. This wasn't enough. The small group market continues to struggle while the business community and carriers remain relatively united in expressing ongoing concerns that:

- Washington's modified community rating limits carriers' ability to offer affordable products in the small group market.
- Benefit mandates are driving premiums and restricting carrier flexibility in benefit design. In particular, the requirement to reimburse any licensed provider whose scope of practice allows treatment covered under the Basic Health program, is the "single most expensive mandate in Washington". From a business perspective benefit mandates eliminate the likelihood that new carriers will be attracted to Washington with affordable products that have been successful in other states. ("Value" plans, set in statute in 1988 to encourage creativity, have been apparently not workable. Small employers want "cheap" coverage options but they also want "value" – these two concepts appear to be in collision).
- The state act as a safety-net rather than a "competitor", helping with premium assistance for low income employees so they can join their small business employer's health care plan.

(*Data that would help assess these concerns is skimpy and therefore used to support all sides. Key to our proposed grant activities is technical assistance from national, other state and local experts that will help identify specific data gaps and data collection activities needed for us to be able to answer critical questions about Washington's small employers and their coverage.)*

Thus, despite early progress expanding insurance in the state, Washington has gone from a leader in health reform to a state struggling to maintain its existing coverage programs. Dramatic increases in health care costs have come face to face with falling revenues and serious budget problems. But a new day is dawning in Washington. In her first month in office, Governor Gregoire submitted executive request legislation "that would allow private employers to purchase health insurance benefits for themselves and their employees and families through the programs administered by the state". In response to addressing business concerns this legislation is evolving in partnership with the Legislature and both Democrats and Republicans have introduced various bills to assist small employers. All parties are committed to expanding access to affordable heath insurance for small employers - this session.

**State Planning Grant History:** Washington wrote its initial grant proposal for the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA) in the summer of 2000, prior to the drop in revenues. By the time we began the grant work in March 2001, revenue projections were changing the face of government - and we immediately stumbled head first into resistance to any discussion of expansions to serve the uninsured.

[28] In 2003, the independently-elected Insurance Commissioner initiated and chaired a task force on covering the uninsured. Although the group was unable to come to consensus on strategies, the Commissioner took lessons from their discussions and crafted proposed (albeit unsuccessful) 2004 legislation involving reinsurance and a premium assistance program for employees of small employers. His work has continued with a recent expert panel convened by the Commonwealth Fund to peer review his latest reinsurance proposal. They concluded that the proposal was premature for Legislative consideration but offered "much potential" for "…dealing with the level and volatility of premiums in … Washington".

Through the initial research phase of our funding we encountered major challenges including: the sad state of the economy and thus people's inability to consider opportunities for "expanding" coverage when sustaining coverage was doubtful and; resistance to "policy lessons" when research and practical findings did not support the pragmatic decisions needed to be made or the perceived value of a specific coverage option (e.g., findings regarding coverage affordability for low-income families and findings regarding the ineffectiveness of small employer pools – as currently designed - to significantly reduce costs).

To work within these challenges we adopted an approach that did not include "pushing" for buy-in on specific options (although our research work did involve developing options); we acknowledged that consensus building on strategies viable in Washington would occur over the long run through processes fed by the work of the grant but not unique to the grant (e.g., the Legislative process and the Insurance Commissioner's Task Force); and we elected to "key into" what people are willing to focus on as common-ground starting points (e.g., employees of small business, children, the state becoming a better partner [especially in areas of administrative simplification], coverage and access in rural areas, and understanding the impacts of Legislative decisions on public program options and the difficulty in sustaining public program gains).

Like many other states with HRSA grants, we received an extension to the initial award as well as three supplemental grants, in 2002, 2003 and 2004. These have enabled the work to continue to-date (and through August 2005), with many activities moving forward. A matrix on the following pages, **Examples of Activities related to Potential Policy Options for enhancing Access to Health Insurance,** summarizes our earlier research on potential policy options, including common approaches being considered in other states. It provides examples of related, subsequent, activities in the state and offers a perspective on the hesitancy of policy makers, in the current fiscal climate, to make significant commitments of *public* dollars at the same time as they are interested in supporting *alternative* financing arrangements for improving access to coverage and care.

**Links to Other State and National Efforts to Reduce Numbers of Uninsured:**
SPG funding has supported Washington in accessing a wealth of research and practical experience from other states, as well as connecting us with a broad set of national policy and technical experts. We have developed strong relationships with these experts, evidenced by the willingness of the key individuals identified in our budget plan to participate in this proposal. As we move forward we will continue to look to these experts and to other states for policy and implementation issues, lessons learned, strategies that have proven successful and pitfalls, and a reality check on planning in Washington. In particular we are interested in design and implementation experiences that will contribute to Washington's testing of ideas around evidence-based benefit design; reinsurance and risk adjustment; public/private pooling partnerships, shared funding, and premium assistance for small employers. Understanding options being tested around the country allows the SPG team to play a "public relations" function, tapping into a broad range of expertise that would otherwise be much less readily available.
In particular, we expect Washington's Pilot and Planning grants to benefit from the experiences of several states, including:

- DirigoChoice, a component of Maine's comprehensive health coverage just operational in January 2005. Ree Sailors, health policy advisor to Washington's previous Governor was instrumental in preliminary discussions around program design issues and options for Dirigo.

Like other states, we are watching Dirigo closely and expect to be able to learn much from their very recent design and implementation activities.

- PacAdvantage, California's successful non-profit small business purchasing pool in operation since 1992. For the first 7 years a governmental entity oversaw PacAdvantage, then known as the Health Insurance Plan of California (HIPC). In 1999, following a competitive bid process, the state turned control of the purchasing pool over to the Pacific Business Group on Health, a coalition of health care purchasers. Analysis related to the extension of PacAdvantage to employers with low-income employees was conducted in California's initial SPG and will be useful input to our work. This recognizably successful program offers us years of experience (public and private) and a realistic perspective on enrollment expectations. In a state of 36 million people, PacAdvantage enrollment is about 150,000. Translated to Washington's population, that would suggest the maximum we might hope to achieve over the long haul would be about 25,000 members.
- Oregon's FHIAP program current design work around premium assistance planning is of particular interest because of its regional implications for families and providers near Washington's borders.
- New York's excess-of-loss reinsurance program and Arizona's aggregate stop-loss reinsurance offer different approaches to government-sponsored reinsurance as a means to reducing premiums and increasing access to health insurance. Their experiences can help Washington build on recent conversations spearheaded by our Insurance Commissioner around design of a reinsurance proposal.

## Examples of Activities Related to Potential Policy Options for Enhancing Access to Health Insurance Covered in Initial State Planning Grant Research

See "*Potential Policy Options for Enhancing Access to Health Insurance Coverage in Washington State*", available at: http://www.ofm.wa.gov/accesshealth/products.htm

| Major Grouping | Specific Options Addressed in Initial SPG Research | Examples of Related Activities Affecting Coverage in WA State 2003 – 2005 |
|---|---|---|
| I. Financial incentives to individuals and families to purchase health insurance (Subsidies include vouchers, tax credits, and direct payments) | Subsidies to assist low income in buying individual coverage | Basic Health and Medicaid 2004 program changes (see section VI) |
| | Subsidies to assist high-risk people in buying individual coverage (state high risk pool) | 2003 and 2004 Legislative discussions explored options for modifying the high risk pool and becoming federally qualified. |
| | Subsidies or reforms for transitional coverage (e.g. COBRA) | 2004 statutory approval for Basic Health to become a "qualified plan" under TAA Health Coverage Tax Credit program – enrollment minimal. |
| | Premium assistance | Medicaid program small but still functioning primarily for dual-eligibles – currently exploring expansion to support limited buy-in to employer coverage |
| II. Financial incentives to employers to purchase employee coverage | • Direct subsidies or tax credits to employers<br>• Play or pay mandate on employers | • Community groups exploring employer contribution options<br>• 2003-2005 legislative discussions re "pay or play" requirements for large employers – bill died in 2005 because employers "doing the right thing" appeared to be negatively impacted |
| III. Health insurance purchasing pools | • Employer-based purchasing pools<br>• Individual or individual/small market purchasing pools<br>• Other community-based purchasing pools<br>• Mobile worker purchaser pools<br>• Consolidated state funded pools | • Safe Table (educational) forums on employer coverage options, and pooling opportunities and consumer-directed options (HSAs etc)<br>• "Local purchasing utility" idea being explored by community group as means of pooling financing (inspired by SPG-SCI community-based coverage & purchasing pool technical assistance meeting)<br>• 2003 statutory approval for low-income seniors to participate in consolidated drug purchasing program for state agencies.<br>• 2004 statutory authorization for collective bargaining agreement for independent home care workers, including health coverage.<br>• Private Fortune 500 companies (including WA-based Starbucks) spearheading collaborative to cover retirees, part time employees & other special populations<br>• Puget Sound Health Alliance formed to improve cost & quality of health care<br>• WA Artists Health Insurance Project plan to develop occupation-based coverage model for WA artists - SPG providing technical assistance |
| IV. Insurance market regulations | • Relief from benefit mandates<br>• Individual and small-group market regulations<br>• High-risk pool expansion<br>• Universal catastrophic coverage | • 2004 Legislative reforms for small employer groups – redefined group size as 2-50, community rating range increased, some benefit mandate relief. Continuing interest for expanding in 2005.<br>• Health screening questionnaire revised in June 2003 to screen additional people out of individual market and into high risk pool<br>• 2003/2004 potential expansions of high risk pool (TAA "qualifications" and "HIV" access) defeated by small business & carriers concerned about increased high risk pool access.<br>• OIC "Let's Get Washington Covered" task force discussions. SPG participated |

| Major Grouping | Specific Options Addressed in Initial SPG Research | Examples of Related Activities Affecting Coverage in WA State 2003 – 2005 |
|---|---|---|
| | | in follow-up reinsurance proposal peer review with recommendations for continued exploration in conjunction with chronic care management for "sickest"<br>• 2005 Legislative passage of mental health parity – small employers exempted |
| V. Direct subsidies for safety net or charity care services (for those for whom insurance may never seem like a viable option) | • Expand state's Community Health Services grant program<br>• Create discount health cards for individuals<br>• Expand federal health professional shortage areas (HPSAs)<br>• Expedite Rural Health Center designation<br>• Increase payment to providers via health plan contracts<br>• Tax credit for not-for-profit hospitals<br>• Tax credit for physicians, physician assistants, and nurse practitioners<br>• Uncompensated care pools | • Expansion of direct grant program to migrant and community health clinics eliminated in 2003-05 budget, funded in 2004 Supplemental budget<br>• Central WA community using discount cards for low-income unins.<br>• Modest expansion of designated HPSA areas<br>• 2004 budget investments in rural infrastructure, increase in health professional loan program & state paid med-mal insurance for retired providers – rural access expanded<br>• 2004 legislation offering med-mal insurance for providers serving in clinics as volunteers<br>• Modifications in DSH payments to "compensate" for elimination of Medically Indigent program in Medicaid via lidded grants |
| VI. Public Insurance Program Expansions | Although options re public insurance are part of our SPG work, our initial background research did not include a review of detailed options. Washington has been a leader in the three areas most commonly discussed, i.e., (1) attain full enrollment of all currently eligible individuals into existing public programs, (2) expand eligibility for children by raising the income eligibility level, and (3) extend coverage for adults – first focusing on parents of eligible children and then on adults without children. | • BH eligibility/benefits reduced 2004 – funding to sustain enrollment at 100,000 proposed in 2005 Gov's budget<br>• Elimination of state funded Medicaid Medically Indigent program<br>• State-funded coverage for immigrant children restored in Gov's 2005 budget<br>• Medicaid children's premium sharing postponed indefinitely<br>• Expansion of SCHIP coverage for pregnant women<br>• Medicaid signature & income verification requirements, adoption of a 6-month eligibility review cycle & termination of 12-month continuous eligibility (reinstated by new Gov in January 2005)<br>• Local initiative to develop consumer-driven, incentive-based coverage option (health reimbursement account + proven preventive care) to potentially pilot in a public program (Health Plan for Life) |
| VII. Other (including Administrative Simplification) | | • 2003 statutory requirement for uniform administrative, purchasing & quality policies across state programs<br>• Public / private partnership (state agencies, hospitals, & private group of insurance carriers to reduce admin. burdens & increase efficiency.<br>• Foundation sponsored community roundtables, dialogues & surveys to identify WA residents values vis-à-vis access & coverage to care<br>• Community initiatives (Kids Get Care) to use access to medical homes and preventive care as entrée to access to insurance coverage (2005 Legislative interest in supporting program still alive).<br>• Collaboration of private carriers & health care providers developed secure digital portal ONEHEALTHPORT for efficient processing of medical records. Current efforts targeting the development of a secure medical records sharing platform. |

## c. STATEMENT OF PROJECT GOALS – LIMITED COMPETITION PILOT

**This Pilot grant will provide** the expert resources and technical assistance needed by Washington State to design a program to help small employers offer and their employees/families purchase affordable, predictable health coverage. The focus of the program is a small employer purchasing pool; a component of the program is premium assistance to help low-income families buy-into employer-based coverage. We will draw on lessons from (1) Washington's experience with Basic Health as one of the nation's original 3-share programs (employer/sponsor, employee/enrollee, state), (2) experience of other states that have implemented small employer pools and assistance programs, and (3) expert researchers who have evaluated the characteristics of successful versus less successful implementations.

The broad goals of the Pilot are to:

- Develop a viable underwriting pool of 6,000-10,000 employees and family members of small business (growing over time) (see Project Description for a discussion of magnitude of impact),
- Design premium assistance strategies including use of individual-based subsidies paid in a group coverage environment,
- Test ideas around development of benefit packages based on best evidence (whether traditional in nature or part of the newer consumer-directed movement), risk management mechanisms such as health-based risk adjustment and reinsurance as a potential for "buying down" the price of insurance (a type of implicit subsidy), and use of community organizations to put a local face on the program (community surveys of small employers show that they want to "buy locally"),
- Develop the specifics of a plan to seek federal matching funds on a non-Medicaid program (via a HIFA waiver), and
- Attempt a pool governance structure that is joint public / private with an option for transition of workable ideas to the private market.

There are three issues that need simultaneous attention if we are to make any inroads for small employers and their employees: (1) affordability of base level premiums, (2) yearly growth and volatility of premiums, and (3) range of options that respond to employer/employee needs. Thus, this pilot is about more than creating 1-2-3 new benefit designs; it's about creating an environment (e.g., shared-risk and funding, evidence-based delivery, community platform) for sustainable, affordable coverage.

**At the end of this grant** we will have addressed the following questions, resulting in the design of a viable small employer purchasing pool, a component of which is premium assistance for low-income employees and their families. An initial task of the project team is review and refinement of this list.[29]

| Area | Questions |
|---|---|
| **Benefit designs and** | • Will product design be coordinated with Basic Health? How?<br>• How will people be able to transition among these products? |

[29] The question areas are generally but not perfectly aligned with the workgroups that will be used in the design phase. Some questions are applicable to more than one group so an initial task of the Project Design Director is to determine how best to divvy up the issues among workgroups.

| Area | Questions |
|---|---|
| **pricing** | • How many designs will there be? Of what type (e.g., preventive/primary care only; catastrophic only; all basics except inpatient hospital; high deductible health savings accounts)<br>• How can evidence-based medicine be operationalized within these designs – will that reduce costs? Improve health?<br>• Will exemption from state mandates and current modified community rating rules improve affordability?<br>• What kind of quid-pro-quos can be made with providers in exchange for preferred rates to lower prices? |
| **Risk Management / Premium Volatility Management** | • Will attention to health-based risk adjustment help persuade carriers to participate? Or the opposite? Will it improve affordability? Reduce volatility?<br>• Will attention to reinsurance for high-cost or high-risk enrollees persuade carriers to participate? Or the opposite? Will it improve affordability? Reduce volatility?<br>• How would implementation of these mechanisms in this limited environment co-exist with markets that don't use them? If used throughout all markets, would they improve affordability statewide? |
| **Shared Funding / Financing** | • How would current public expenditures be restructured to cover more people?<br>• How would shares for each contributing partner (employer, employee, public) be determined to maximally encourage coverage?<br>• What design characteristics would maximize the opportunity for federal match through a HIFA waiver for a non-Medicaid program?<br>• What funding approaches would most encourage family coverage?<br>• How can an employer group program be meshed with an individual-based subsidy program? In the context of employer coverage, what are the advantages and disadvantages for both employer and employee of basing the subsidy on family income versus employee wage?<br>• Should the premium assistance component be limited to purchasing within *this* pool alone or be available outside the pool as well? |
| **Public / Private Linkages** | • Will this program be affiliated with Basic Health? How?<br>• How would it work with Medicaid and SCHIP?<br>• How will the program as a whole relate to the private market (e.g., publicly financed but privately offered)?<br>• How will product design be coordinated with private market products – existing and evolving (e.g., high deductible plans; Association Health Plans; Health Savings Accounts)?<br>• In what ways can this program take advantage of existing public infrastructure? Existing private infrastructure?<br>• What are the expectations about moving between this program and other markets?<br>• If exempt from state mandates and rating requirements, what are the consequences for carriers and other organizations not relieved of these |

| Area | Questions |
|---|---|
| | requirements?<br>• What opportunities / program characteristics will provide incentives for carriers to participate?<br>• How will the program coordinate with local community and business organizations so that employers can "buy locally", as is their preference? |
| Targeting | • How will the program meet the needs of small employers in different areas of the state?<br>• How will the program meet the needs of small employers with different work force characteristics (e.g., employees are predominantly full-time versus part-time, predominantly low-wage or not, predominantly female or not, predominantly younger or not, predominantly one versus multiple-employer)?<br>• What would be the pros and cons of targeting specifically to micro firms (less than 10 employees) where offer and take-up rates are lowest?<br>• Should we consider the age of a firm as we refine our targeting? Are older, established firms more likely to be in a position to consider coverage?<br>• How will the program handle the issue of crowd-out (e.g., is "employer hasn't offered coverage for at least six months" sufficient? Too much?) |
| Governance | • Would the governance structure be public, quasi-public, or private?<br>• Would it be statewide or local?<br>• How would it be operationalized and financed?<br>• Should sponsorship by a large purchasing coalition (e.g., Puget Sound Health Alliance) be considered (similar to PacAdvantage and PBGH)? |
| Implementation | • What lessons are there from Basic Health's earlier attempt at employer coverage, Basic Health's current Sponsor program, and other states' experiences that need to be incorporated into the design?<br>• In the end, what design elements need to be tweaked to make the program easy to access and use for employers and their employees?<br>• Should the program be implemented statewide or phased-in? If phased-in, how (e.g., piloted in various communities)?<br>• Are there specifics of language that need to be attended to in the context of an employer coverage program, e.g., replace subsidy with "earned health credit"?<br>• How should the procurement process work (e.g., piggy-back on existing state agency process)? |
| **Monitoring / Evaluation** | • What specific policy & program management questions do we want to answer via monitoring? Via evaluation?<br>• What data need to be collected to monitor real-time impacts (e.g., to judge if the plug needs to be pulled because consumers are being hurt)?<br>• What data need to be collected to evaluate the longer-term impacts such as impacts on small employer offer rates, employee/family take-up rates, premium levels and premium volatility, carrier participation and satisfaction, impacts on markets outside the purchasing pool? What else |

| Area | Questions |
|---|---|
| | needs to be on this list?<br>• What process, and how much would it cost, to collect this data? Who would do it?<br>• How long would the program have to run to have the ability to conduct a viable evaluation? |

We have been asked why the public sector is taking on this issue – couldn't the private sector handle it equally well?[30] We offer the following in response:

1. Consumer protection: We need to be able to try innovative ideas in a controlled environment where if the ideas are not working and consumers are getting hurt (beyond some marginal threshold) the plug can be pulled quickly.
2. The stakes: The higher the societal stakes, the less that private markets should be entrusted to take the driver's seat. Where there is a compelling public interest, as there exists regarding the public's health, markets are best used as tools but not left to their own self-interests. Simply because markets work outstandingly in some arenas doesn't mean they do so in all arenas.
3. Areas of expertise / opportunity: Washington's public sector has resources and experience that are not readily available in the private sector, e.g., providing subsidies for low-income, health-based risk adjustment to encourage coverage of anyone regardless of health status. There are also opportunities available to the public sector not available to the private, e.g., the potential for receiving federal matching dollars without any additional state investment.

**Additional Proposal Goals**: Although the primary goal of this project is developing the Pilot described above, there are two other goals as well. First, we recognize the importance and need for continuing our long-standing **role as a resource** on Washington's uninsured and how to get them covered. Thus, we have earmarked time for SPG staff to fulfill this need, albeit at a much more modest level relative to the resources earmarked for the Pilot program. Second, we recognize the importance of **fulfilling grantee obligations** to HRSA so we have allocated SPG resources specifically to meeting key program expectations, that is, attending grantee meetings, submitting all required reports, assisting in developing national and summary reports, and providing assistance to other grantee and non-grantee states.

[30] It has been suggested that the private market could address the growing number of uninsured workers and families associated with Washington's small businesses if current restrictions (such as mandates and modified community rating rules) were lightened. Washington markets have had the opportunity to develop and offer "limited benefit plans" for many years to employers with less than 26 employees and more recently to employers with fewer than 50 employees. To-date there hasn't been much response to this opportunity, either in terms of carriers offering or employers purchasing. In fairness, the "limited benefit plans" are not totally mandate-free, some restrictions remain (such as covering every category of provider, rating bands) and it is argued that these are the big culprits in making coverage unaffordable to small employers. We agree that it is perhaps time to see what can be done in a less restrictive environment; we simply feel the testing should occur in a controlled arena where if consumers are being hurt the "experimental trial" can be ended quickly. That would not be the case if left to the market.

**STATEMENT OF PROJECT GOALS – LIMITED COMPETITION PLANNING**
The goals of the Planning project are the same as those of the Pilot. The difference between the two proposals is the degree to which the SPG program can contribute to meeting these goals and the *quality of the end design in the absence of the expert resources* (national and local consultants, employer pool and premium assistance administrators from other states, SPG staff) that would be available through the more extensive Pilot program.

Washington is committed to developing a program to help small employers offer and their employees/families purchase affordable, predictable health coverage. *SPG funding will help ensure that we maximize the chance for a successful design.* So while we would certainly be tickled to receive a Planning program award, we would be thrilled to receive the more extensive Pilot award.

## d. PROJECT DESCRIPTION - LIMITED COMPETITION PILOT

**Pilot Description**: This Limited Competition Pilot proposal focuses on one coverage expansion option. The option is to develop a purchasing pool for small employers and their employees/families. A component of the program is premium assistance for low-income workers/families. Broad goals and specific questions to be addressed in the project are described in the Statement of Project Goals section.

**How Pilot Was Selected**: As is the tradition in Washington State, consensus on major public policy issues is achieved through the Legislative process. For the last four years, SPG-funded policy and data analyses have supported that process. Currently, there are two coverage options around which substantial agreement has evolved: (1) design a program to assist small employers and their employees/families that are being priced out of coverage and (2) develop a plan that makes incremental progress toward expanding coverage to all children by 2010-11.

This Pilot addresses the first because it is the more focused and specific of the two. While there is substantial agreement on the end goal of covering all children by 2010-11, there is less agreement on approaches needed to get there.[31]

Information developed during earlier phases of SPG funding helped to identify this Pilot as an area where action could be taken to address Washington's increasing uninsured rate. For example, our data clearly show that the characteristics of Washington's uninsured population tend to be quite consistent over time (even as individuals themselves move in and out of coverage). These people are *overwhelmingly part of working families*, are frequently low-income, and are often employed in the service, agricultural, retail, and construction industries. Furthermore, our analyses show a *decade long decline in employer-based coverage in Washington*. (This decline has been accompanied by increases in public program coverage; however, not to the extent of filling the gap.) Our earlier work pinpoints that it is getting *more and more difficult for Washington's small employers to offer and their employees/families to purchase* health insurance coverage. The issue is

[31] Legislation is currently in-play that would require the policy and fiscal committees of the Legislature to work together during the 05-07 biennium to develop a coverage strategy for children. We estimate there are some 97,500 uninsured children in Washington (2004 figures); close to 70% are in families with incomes up to 250% of federal poverty and thus potentially eligible for public programs. If Governor Gregoire's proposed budget is adopted, close to half of these children, including immigrant children, may once again have access to coverage.

one of both affordability and quality, i.e., the ability to offer *coverage that is of value* to the parties involved in the purchase (employer and employee). In addition, our work makes it clear that the issue is most acute for small employers whose work force is dominated by *low-income workers* and for *"micro" employers* with fewer than ten employees.

In the end, the *decision to apply for this specific Pilot* was the result of where it fit in our conceptual framework of the uninsured (described below), its consistency with previous data analyses, and the fact that executive/legislative agreement and commitment to action on this issue are as high as they are likely to ever be.

**Commitment to Implementation**: Notwithstanding the budget difficulties of the last few years and the recent increase in Washington's uninsured rate, we have a long-standing commitment to creating a "culture of coverage" for all residents, a vision consistent with the full-coverage goals of Healthy People 2010 and the SPG program.

An initial step towards helping small employers and their employees/families who are being priced out of the market was taken in the 2004 session when Washington enacted legislation to help shore-up the small group market. As a follow-up, the 2005 session has seen a slew of bills introduced by a variety of legislators of both parties to assist small employers with health coverage. Governor Gregoire introduced legislation to help small employers and their employees by creating a small business assistance program; she has been working with the Chairs of the House and Senate health care committees to find solutions. Her bill specifically targets January 2007 as a coverage start-date. As is noted in her letter of support, if her bill does not pass she is prepared to follow-through with her ideas based on executive order to her administrative agencies. The Governor has made it clear she is interested in creating coverage opportunities as soon as possible[32].

**Relationship to State's Overall Coverage Strategy**: By way of background, we conceptualize Washington's uninsured population using the following 3-variable table. People are grouped broadly by age (child or adult), whether they experience spells of uninsurance that are of long duration (chronic) or are transitional in nature (periodic), and by the family's connection to the labor force. Coverage expansions can be targeted to a given cell, row or column of this table, e.g., children who are chronically (long-term) uninsured and are part of families with no connection to the labor force (shaded box). Furthermore, each cell, row, or column of this table can be dissected further to better hone in on a group of interest.

Example of Broad Groupings of Washington's Uninsured Population

| | | Child | | Adult | |
|---|---|---|---|---|---|
| | Uninsured Status | Chronic | Periodic | Chronic | Periodic |
| Family Connection to Labor Force | Unemployed / not in labor force | | | | |
| | Self-employed | | | | |
| | Employed | | | | |

[32] Governor Gregoire's proposed 05-07 biennial budget includes 3.3 FTEs and $274,000 to develop a program to support small business. These resources will extend beyond the Pilot grant planning into the first year of operation.

The table is repeated below to give a sense of where the Pilot proposal fits in Washington's overall coverage strategy. The plan to "cover all children by 2010-11" applies to the area labeled **(1).** For the adult-employed section there are two ideas in play – **(2)** is to assist small employers (our Pilot proposal); **(3)** centers on discussions about obligations of large employers re covering workers. The areas marked **(4)** and **(5)** are a bit more difficult – the need is recognized but ideas for specific coverage approaches are few. Strategies for group **(4)** (i.e., self-employed adults) focus on shoring-up the private individual market, the state's high-risk pool, and sustaining the Basic Health program. The strategy for area **(5)** (i.e., unemployed / not in the labor force adults) is less about coverage per se than about sustaining the community clinic / hospital safety net. For example, Governor Gregoire's proposed budget preserves state grants to community clinics and increases Medicaid reimbursement rates for hospitals.

Clearly this schematic is a very simplistic view of who the uninsured are and strategies for coverage given that all uninsured have multiple characteristics and most coverage strategies cut across these characteristics. Our Pilot proposal is a good example: covering families is an aim of the Pilot even though we show it on the table as targeting adults.

Example of Broad Groupings of Washington's Uninsured Population

<table>
<tr><td></td><td></td><td colspan="2">Child</td><td colspan="2">Adult</td></tr>
<tr><td></td><td>Uninsured Status</td><td>Chronic</td><td>Periodic</td><td>Chronic</td><td>Periodic</td></tr>
<tr><td rowspan="3">Family Connection to Labor Force</td><td>Unemployed / not in labor force</td><td colspan="2" rowspan="3">(1)</td><td colspan="2">(5)</td></tr>
<tr><td>Self-employed</td><td colspan="2">(4)</td></tr>
<tr><td>Employed</td><td colspan="2">(2) & (3)</td></tr>
</table>

Target Population, Scope and Magnitude: The target population comes from the approximately 150,000 uninsured employees (and their dependents) of small business – a substantial portion of whom (around 40%) are low-income and/or work in micro firms of fewer than 10 employees where affordability issues are most acute. This 150,000 represents about one-quarter of Washington's uninsured. The other three-quarters are members of families that are unemployed or not in the labor force (~ 29%), identify themselves as self-employed (~ 33%), or are employed by large business (~ 13%).

The specific target population for this program is a subset of the 150,000 workers/families associated with small business – it is the roughly 112,000 that are full-time. We are focusing on small businesses whose workers are predominantly full-time because these employers are the most likely ones to offer coverage if provided affordable, predictable, administratively simple options, and full-time employees are the most likely to take-up that coverage if available.

We identified this target population via several channels: (1) alignment with our conceptual framework and other coverage strategies, (2) lessons from earlier SPG-funded data and policy analyses, and (3) an area where there is substantial agreement that action needs to be taken.

The target population for the Pilot is shown below using the conceptual framework described above. The "A Table" is the first cut of our target population, that is, children and adults who encounter both long-term and transitional periods of uninsurance AND are parts of families with a connection to the labor force (shaded row). The "B Table" refines the targeting by looking at where we find

these uninsured, employed families based on workplace characteristics. That is, we are targeting uninsured, employed families that work for small businesses, where the majority of workers are full-time. A particular interest is micro businesses where lack of coverage (due to offer and take-up) is highest. We are not targeting by wage characteristic of the business (e.g., predominantly low-wage, not low-wage, or a mixture) – we want to include businesses of all wage types. An open issue is whether there is value in further targeting businesses by the length of time they have been in operation, presuming that businesses that have been around awhile might be better positioned to psychologically and fiscally offer coverage.

Table A: First Cut at Target Population Based on Uninsureds' Characteristics

| | | Child | | Adult | |
|---|---|---|---|---|---|
| | Uninsured Status | Chronic | Periodic | Chronic | Periodic |
| Family Connection to Labor Force | Unemployed / not in labor force | | | | |
| | Self-employed | | | | |
| | Employed | | | | |

Table B: Second Cut at Target Population Based on Business Characteristics[33]

| | Small | | Large | |
|---|---|---|---|---|
| | FT | PT | FT | PT |
| LW | | | | |
| Non-LW | | | | |

With respect to **scope**, the design process will address whether the Pilot program would be best tested on a statewide basis or in collaboration with specific communities. There are advocates for each.

In terms of **magnitude of impact**, it is important to manage expectations of what can be accomplished "number-wise" with this Pilot. For example, one of (if not the) most successful purchasing pools for small business is California's PacAdvantage (sponsored by the Pacific Business Group on Health). The enrollment is roughly 150,000 in a state of 36 million people. Applying that proportion to Washington, the maximum enrollment we could ever hope for (in the long-run) is ~25,200 covered lives. Thus, in the best of all worlds, this program would ultimately impact about 4.2% of our uninsured; reducing the rate of uninsurance by just under one-half of one percent.[34] However, one of our goals is also to test ideas (see Statement of Goals) that could be exported to the private sector or incorporated into public programs and, as a result, have an impact

[33] Small = 50 and under employees, Large = over 50 employees; FT = full time and PT = part time; LW = low wage and Non-LW = not low wage.

[34] A very preliminary guesstimate of per person design costs ranges from $24 to $100 depending on grant award, level of state resources used, and size of pool. (This is design costs only and does not include on-going operational costs or subsidies.)

on covering the uninsured that is larger than reflected by this one pool. Admittedly, we have no way of quantifying this potential impact.

**Tasks and Activities**: Project goals, tasks and activities, timetable, task leads and coordinating parties, anticipated results, and evaluation/measurement tools (identified as deliverables) are presented in the Project Management Plan (PMP). The following is a narrative version of that information.

In reviewing the task descriptions (and PMP) and evaluating our approach to this project, the following may be helpful. The State Planning Grant (SPG) team is not the lead of this project. The lead is what we have generically called the "home agency" and will be designated by Executive/Legislative decision makers. We are 99% certain the "home agency" will the Washington State Health Care Authority, which is currently responsible for running the Public Employees Benefits Board and Basic Health programs.

We envision that the home agency will appoint two project directors, each taking the lead at different phases of the project. The Design Director is responsible for all aspects of project management through the design phase (e.g., creation of project management team and plan, coordination of all required work, facilitation of stakeholder input, and accountability to decision makers for project progress). As the project moves into the implementation phase, the Operations Director will assume primary project responsibility for ensuring that all implementation bases are covered. Both the Design and Operations Directors will be "working managers" who take active roles in the day-to-day design and implementation work.

The role of the SPG program in the project is two-fold: First, SPG staff will provide technical assistance primarily through the design phase and somewhat into the implementation phase (i.e., through August 2006). Specifics of this technical assistance are included in the PMP and generally center on policy analysis and synthesis, data analysis, peer review (in conjunction with consultants/experts), and meeting preparation and participation. SPG staff will take a lead role regarding the monitoring/evaluation plan. Second, the SPG award will be used to pay for expert consultants and small business program developers/administrators (e.g., people running pools for small employers). The primary roles for the consultants/experts are also shown in the PMP and generally center on attendance at 1-2 day intensive design meetings and peer review of various design-related work products. SPG staff will ensure that the work of the consultants is consistent with this proposal.[35]

[35] Experts who have agreed to participate in the Pilot design (pending agreed-upon contracts if Washington receives an award since we legally cannot commit to anyone in the absence of an award) include Deborah Chollet, Mathematica (reinsurance, general market knowledge, modeling); John Santa, Center for Evidence-based Policy (evidence-based policy & benefit design); James Matthisen, Mercer Human Resources Consulting (benefit design & pricing, risk adjustment, actuarial modeling); State Health Access & Data Assistance Center (employer data, focus groups, program evaluation); Institute for Health Policy Solutions (small employer pooling and premium assistance); Cindy Watts, University of Washington (risk adjustment, reinsurance, program evaluation). We have yet to contact people who are running successful small employer pools or premium assistance programs in other states but anticipate no problems in doing so. Programs of interest include PacAdvantage in California, Oregon's Family Health Insurance Assistance Program (FHIAP), and the small employer programs in Maine (as part of Dirigo) and Rhode Island. Equally important, we plan to tap into local resources through initiatives such as the Puget Sound Health Alliance, a regional partnership of health care purchasers, plans, health care professionals and patients collaborating to

We have tried to structure the project so that it can begin relatively soon and, even in the absence of an SPG award, can move forward albeit at a much less "informed" level. The SPG funding will provide the expert assistance that state agencies are unable to afford on their own and significantly increase the chance of designing a successful program at the get-go.

Finally, we set a go-live date of January 2007 and built our timeline around it. The date coincides with the State Health Care Authority's standard procurement schedule – the agency goes out for bid in spring for the following calendar year (e.g., April-May 2006 for the 2007 calendar year). A primary question to be addressed during the design phase is whether it's appropriate and effective to piggyback on the HCA's standard procurement process.

**GOAL 1**: There are 13 tasks, described below, associated with the design and development of the small business assistance program, which is the major focus of our Pilot proposal.

**Task 1** (May 05-Aug 05) covers all pre-project planning activities. These include appointment of the Project Design Director and Project Operations Director within the "home agency"; refining and finalizing the project plan, staffing, and governance approaches; drafting background synthesis reviews on design-related topics; doing the planning and preparation for establishing the topic-specific work groups; pulling together initial plans for the Task 3 "experts intensive"; holding an initial stakeholder meeting to review project goals and general direction, and to solicit work group volunteers; and doing all the legwork needed for consultant contracts (pending an award). Although Task 1 occurs before the SPG award period, SPG staff have capacity under current funding to assist with drafting the background literature reviews on design-specific topics, specifically noting issues relevant to Washington's situation. The design-related topics will be finalized during this task but initial thinking is that they will roughly parallel the workgroups and are likely to include Benefit Design (e.g., evidence-based versions of several options, pricing), Financing & Funding (e.g., from where will dollars come and to whom will they flow, including premium assistance), Risk Management (e.g., risk adjustment and reinsurance), Governance, Marketing and Outreach (including education), Operational Implementation, Monitoring and Evaluation.

Under **Task 2** (Sept 05) the consultants/experts and workgroup leads will peer review the draft literature/synthesis papers in preparation for Task 3. They will be asked to look for unidentified or misidentified issues, flaws in thinking, and lessons that fit Washington's specific context and experience. The timing on this might be tight given that we cannot get consultant contracts in place until after the SPG award announcement. However we hope to have all the legwork done for the contracts so we are good-to-go if we receive an award.

**Task 3** (Sept 05) is where we bring our consultants and small employer pool experts together with project staff for a one or two day "Intensive". Although we're concerned about the size and will continue to think about it, our current idea is a meeting of less than 25 people (e.g., 6 consultants, 2-3 successful "pool and/or premium assistance" program managers, 7 work group leads, Design Project Manager, Operations Project Manager, 3 SPG staff, and possibly a meeting facilitator). This

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improve quality and reduce costs in health care delivery. The Washington State Health Care Authority is a member of the Alliance and also currently employs one of the nation's long-time experts on small employer purchasing organizations, Ree Sailors.

is a down-and-dirty work meeting; some of the work will be done in smaller sub-groups and some with the entire group. At the end of this meeting we want to be assured we have identified the universe of policy, design, and implementation issues that must be addressed, have a clear understanding of strategies and tactics that have succeeded elsewhere and how they may or may not work in Washington, have identified any data and knowledge gaps that are critical to address (i.e., without that data or knowledge the design is doomed), and reached agreement that our plan of action will result in a successful program design. *Task 3 is one of the mission-critical tasks for the consultants* (the other is Task 9).

Fed by the information developed above, **Task 4** (Oct 05) involves briefing meetings for stakeholders, staff and workgroup participants (other than workgroup leads). The purpose of the briefings is to orient everyone to the project strategy, tactics, and issues. We are still deciding if one grand meeting or a series of smaller meetings with targeted groups would be most effective. For example, we might want separate briefings of executive/administrative agencies, legislators and staff, workgroup participants, community/business groups, all other stakeholders. The final decision on this will need to balance time and physical resources with effectiveness. The difference between the stakeholder informational meeting in Task 1 and these briefings is degree and depth of information to be provided. Task 1 is "big picture"; Task 4 is more detailed. A critical part of the Task 4 briefings is to provide enough project detail that we can gather constructive feedback on issues, approaches, and concerns. (Our Legislature meets annually beginning in January, and often holds work session meetings in early October and December – it's likely that we would have to work some of our briefings around these dates.)

**Task 5** (Oct 05-Dec 05) involves developing and implementing a strategy for addressing the data and information gaps identified at the Task 3 "Intensive". Although we suspect there are all kinds of data or information that people might like to have, our goal is to focus on what is mission-critical. We do not anticipate doing any primary data collection (e.g., surveys) although some focus-group work is a possibility. However, several of our community partners have conducted focus groups with small employers and we are already incorporating their findings into our design activities. In general, we hope to fill any mission-critical data or information gaps through re-analysis of existing data and policy sources.

**Task 6** (Oct 05-Dec 05) is where much of the heavy lifting of this project occurs. Workgroup leads will convene their topic-specific workgroups to hash out specific design elements and develop recommendations. Under the direction of the Project Design Director, workgroup leads will be responsible for coordinating work across groups. We will develop a standard template for workgroups to use in laying out issues, synthesizing discussions and options, and providing recommendations and rationales. We expect to make substantial use of consultants/experts in providing peer review of these decision packages. The need for any authorizing legislation will also be identified and draft bills developed.

**Task 7** (Jan 06-Feb 06) is the "Workgroup Caucus" meeting where we bring the individual workgroups together for a 1-2 day "Intensive". This meeting is where "it" happens -- all the design pieces from the various workgroups are put together to create an overall small business assistance program design **(Major Milestone 1**). As with Task 3, this is a down-and-dirty work meeting; some of the work will be done in smaller sub-groups and some with the entire group. At the end of this meeting we want to be assured that all our design features mesh, identify any outstanding issues and gaps and how they will be addressed, and confirm the implementation plan and schedule. A

synthesis of the entire program design will be written up and provided to the consultants/experts for peer review (Task 9). (Although we anticipate that some or all of the consultants/experts will attend this caucus and have budgeted accordingly, we may revisit this decision as the project progresses. Our primary interest is in ensuring sufficient time and resources for these advisors to provide in-depth peer review of the synthesized program design that will flow from this meeting.)

The focus of **Task 8** (Jan 06-Feb 06) is progress reports to the Administration and Legislature. These could take the form of formal reports (e.g., if required by pending legislation), presentations at legislative committee work sessions or Executive branch meetings, or informal small group briefings. Regardless, we will target this period for updating Governor's Office staff, the Legislature, and other Administration and Elected Officials. (Washington's annual legislative session begins in mid-January and both policy and fiscal committees hold work sessions during the first few weeks.)

As referenced earlier, **Task 9** (Feb 06-Mar 06) is the second *mission-critical task for the consultants/experts*. The synthesis of the entire program design (from Task 7) will be written up and provided to them for in-depth peer review and critique. Their recommendations for refinement are critical for developing the final design of the small business assistance program.

**Task 10** (Mar 06) is similar to Task 4 in that we will again convene stakeholders and other interested people that were not intimately involved in the workgroups. This meeting is aimed at non-Administration and non-Legislative people because we will have recently briefed them as part of Task 8. As with Task 4, we are unsure at this time whether one grand meeting or a series of smaller meetings with targeted groups would be most effective. We will make this decision as the project progresses. Our goal is to have everyone be as informed as possible and prepped to assist with implementation. Most importantly, this will be the last opportunity for input to affect the program design. The timing of Task 10 and Task 9 is a bit tricky and tight and may need to be refined. Our intent is to use the design synthesis and the peer reviewers' feedback from Task 9 as the basis for Task 10 meetings.

**Task 11** (Feb 06-Apr 06) is decision time **(Major Milestone 2)**. The design will be finalized and ready for the Project Design Director to present to decision-makers for a final Go-No Go implementation decision. Because of the extensive amount of stakeholder and briefing activities built into the project plan, we hope all the groundwork will have been laid and there will be no surprises at this point. However, as with everything, the devil is in the details and this is the point at which decision makers need to buy-off on the details not just the concept. In addition, there may be aspects of procurement (e.g., will it follow standard State Health Care Authority processes) that influence the Go-No Go decision and need to be kicked into gear immediately. As a result, Task 11 also includes procurement readiness activities (e.g., drafting an RFP). Note that in earlier tasks we will have identified implementation issues (Task 3), confirmed an implementation plan and schedule (Task 7), and had the implementation plan and schedule peer reviewed (Task 9). So Task 11 is not the first time procurement is addressed -- it will have been a part of the planning process all along. In Task 11 it simply gets kicked into gear.

In **Task 12** (May 06-Jan 07) the lead responsibility for the project switches from the Design Director to the Operations Director. The Operations Director is accountable for making sure that all operational policies and procedures, contracts, administrative system changes, training needs, marketing and outreach activities are in place, tested, and ready to go. This person is responsible

for following through on all implementation issues, plans, and schedules identified in Tasks 3, 7, and 9. Recall that there are specific workgroups on some of these issues so Task 12 is not the first time they are addressed – it is simply the point in time at which efforts are refocused from design to implementation.

**Task 13** (Jan 07) is go-live time **(Major Milestone 3)**. Enrollment and coverage begins – small employers and their employees are informed and poised to purchase health insurance coverage through the small employer assistance program.

**GOAL 2**: There are two tasks (**Task 14 and Task 15**) associated with Goal 2 of the Pilot. Although our Pilot proposal focuses on developing a specific coverage option, we don't feel we can or should walk away from the clearinghouse role we have developed and played for the last four years under SPG funding. People have come to rely on us for expert assistance on issues and questions related to Washington's uninsured population. In **Task 14** we focus on continuing our data analysis role, e.g., providing technical assistance on when, where, and how to use certain data sources, conducting ad-hoc analyses in response to questions from various private, public, non-profit, and community groups, and doing self-initiated analyses to prod discussion of issues. **Task 15** is the policy analogue to Task 14 – it allows us to continue as an expert resource vis-à-vis questions and issues on coverage strategies, e.g., providing input on effective coverage strategies to consider, doing policy analyses on of-the-moment ideas such as pay-or-play for large employers, and providing input on specific legislation intended to eliminate barriers to coverage or affecting public program coverage. There are always new people coming on the scene and they value this resource role; even people who have been around for a long time but deal with multiple issues are relieved to be able to pick up the phone and get real-time help on understanding policy and data issues related to covering the uninsured.

**GOAL 3**: The four tasks (**Tasks 16, 17, 18, and 19**) of Goal 3 address our commitment to fulfilling HRSA's grantee requirements. Because we currently have SPG funding we clearly understand the commitments and are fully prepared to meet these obligations. Specifically, at least one member of the SPG team will attend and actively participate in the quarterly grantee meetings (including pre-meeting planning sessions and preparation of meeting materials as needed) **(Task 16)**; we will meet all progress, final, and financial reporting requirements using formats and schedules set by the HRSA Project Officer **(Task 17)**; we will cooperate in preparing consolidated national reports and summary reports to the Secretary of HHS (including sharing materials and lessons, providing data, and assisting in review of products) **(Task 18)**; and, we are happy to act as a resource to other states (grantee and non-grantee) and to organizations providing assistance to other states **(Task 19)**.

**Implementation and Evaluation Plans**: We are targeting a go-live date of January 2007. As noted above, the date was selected to coincide with the standard procurement timeline of the State Health Care Authority. It is also the date used by the Governor in the legislation she introduced this year to create a small business assistance program. The Governor has been clear that she is interested in action not simply more planning and wants to see additional people have coverage opportunities as soon as possible. Also, as discussed above, the date could change (i.e., perhaps be sooner) if during the design phase we determine there is a better alternative than using the contracting process of the Health Care Authority.

We have included a specific workgroup on monitoring and evaluation of the Pilot. Examples of the issues it will address include the specific real-time monitoring and longer-term evaluation questions to be answered; data collection needs, processes, and costs; and length of time for the program to run before a viable evaluation can be conducted. A Deliverable of the project is a specific monitoring/evaluation plan.

**Applicability to Other States**: The nexus of declining employer-based coverage, pressure on public programs to fill the resulting gap, decreasing public revenues, and the political interest in the difficulties of small business vis-à-vis offering coverage makes targeting this population a logical move.

Clearly, many other states have tried (are trying) to create purchasing pool-like arrangements, with and without premium assistance, for small employers and their employees/families. Some have had more success than others. Quite frankly, our first take on the "applicability" question is an interest in *importing* to Washington what is applicable *from* these other states and programs (rather than the reverse). Having said that, we nonetheless hope to test ideas that may have lessons for other states. None of what we want to try is new. What we *do* hope is new is how we put the pieces together so that they are effective in encouraging small employers to offer and their employees to purchase coverage. We want to explore ideas around use of health-based risk adjustment, reinsurance as a potential for "buying down" the price of insurance (a type of implicit subsidy), design of individual-based subsidies offered in a group coverage environment, development of benefit packages based on best evidence (whether traditional in nature or part of the newer consumer-directed movement), ability to receive federal match through a HIFA waiver for a non-Medicaid program, and use of community organizations to put a local face on the program (community surveys of small employers show that they want to "buy locally").

**Commitment to Meeting Four Key Program Expectations**: Goal 3 (Tasks 16-19) of the project, described above, specifically addresses our commitment to meeting the four key program expectations of attending grantee meetings, submitting all required reports, assisting in developing national and summary reports, and providing assistance to other grantee and non-grantee states.

## PROJECT DESCRIPTION – LIMITED COMPETITION PLANNING

The goals and general approach of the Planning grant project are the same as those of the Pilot except as noted below. The difference between the two is that the scope of activities for which we are requesting SPG funding is smaller under the Planning proposal compared to the Pilot. So while the general approach outlined above does not change, the degree to which SPG can help make the outcome better than it might otherwise be does change – there simply won't be access to the same level of expertise.

Information provided above for the following sections is the same for the Planning proposal as it is for the Pilot:

- Pilot Description
- How Pilot Was Selected
- Commitment to Implementation
- Relationship to State's Overall Coverage Strategy
- Target Population, Scope and Magnitude

- Implementation and Evaluation Plans
- Applicability to Other States
- Commitment to Meeting Four Key Program Expectations Tasks and Activities

The differences between the Pilot and Planning Proposals are in the Tasks and Activities section as noted below.

*Goal 1: Small Employer Assist Program (Tasks 1-13)*

- Funding allocated to tasks 2-13 will support approximately 1/3 of the technical assistance provided by SPG staff in the Pilot grant.
- Consultant time for task 5 (filling data gaps) not funded in the Planning grant.
- Consultant time for task 6 (Topic-Specific Workgroups) not funded in the Planning grant.
- Consultant travel and time for task 7 (Workgroup Design Caucus) not funded in the Planning grant.
- Consultant time (122 hours) targeted to task 9 (Design Peer Review) in the Planning grant is approximately 2/3 of consultant expertise available to task 9 in the Pilot grant.

*Goal 2: Maintain Central Resource re Data and Coverage Strategies (Tasks 14-15)*

- SPG staffing allocated to tasks 14-15 to continue the grant role as a central resource for information on Washington's uninsured and strategies for increasing access to coverage is approximately 50% of staffing for Goal 2 in the Pilot grant.

*Goal 3: Fulfill HRSA Grantee Commitments (Tasks 16-19)*

- Consistent with Pilot proposal

## ii. Project Management Plan: Proposed Limited Competition PILOT Grant Activities (September 2005 – August 2006):

**Goal 1: *Small Employer Assist Program*: Estimated budget - $340,200, estimated staff – 1.85 FTEs (Tasks 2-13)**

| Tasks and Activities | Timetable | Lead (L) / Coordination (C) | Anticipated Results | Evaluation/Measurement |
|---|---|---|---|---|
| **Task 1:**<br>Pre-grant preparation (to occur *before* Pilot grant award; early start needed to support implementation deadline)<br>• Project directors (design & operational) assigned by Home Agency<br>• Project plan, governance structure, staffing, etc. review / refinement<br>• Background literature reviews / synthesis analyses<br>• Workgroup resources planning (confirm # and focus of workgroups; solicit leads & participants, etc.)<br>• Preliminary stakeholder informational meeting<br>• Planning for Task 3 "intensive"<br>• Preliminary consultant contract legwork | *May '05 – Aug '05* | L: Design Director<br><br>C: State agencies; Stakeholders; Consultants / experts; SPG staff<br><br>SPG staff role = assist in drafting background literature reviews / synthesis papers<br><br>(SPG staff role can be accommodated under current funding) | Total project resources (staff and workgroups) identified and assigned; available literature summarized as background for task 2; stakeholders informed & on-board with program goals & broad direction (big picture); consultants ready to begin work Sep '05 | **Deliverables**:<br>Draft reviews / syntheses of literature<br>Detailed project plan<br>Draft consultant contracts (awaiting signature pending award)<br>Workgroup assignments |
| **Task 2:**<br>Peer review by consultants / program experts / workgroup leads of draft synthesis papers – as preparation for Task 3 "intensive". | *Sep '05* | L: Consultants / experts (SPG $$ for time)<br><br>C: Design Director; Workgroup leads; SPG staff<br><br>SPG staff role = facilitate peer review process; respond to issues raised | Background materials ready for Task 3 "intensive;" Task 3 participants ready to "hit ground running" based on review of synthesis papers | **Deliverables:**<br>Drafted, reviewed, refined synthesis papers. |

| Tasks and Activities | Timetable | Lead (L) / Coordination (C) | Anticipated Results | Evaluation/Measurement |
|---|---|---|---|---|
| **Task 3:**<br>"Experts Intensive": convene national experts, state administrators from successful small employer programs, workgroup leads, etc. for 1-2 day down-and-dirty work meeting<br>• Review underlying strategies/platform for success in existing programs<br>• Identify policy and implementation issues; refine list of questions to be addressed<br>• Assess data needs<br>• Refine project plan | *Sep '05* | L: Design Director<br><br>C: Operations director;<br>National and state consultants (SPG $$ for consultant travel and time);<br>SPG staff;<br>Workgroup leads<br><br>SPG staff role: Draft policy / implementation issue matrix as basis for meeting discussion; Present "known" data at meeting & facilitate discussion on gaps. | Clear understanding of strategies that have worked in past; program design policy and implementation issues and needed analysis clearly identified; data availability, gaps and sources confirmed; agreement reached on remaining project steps<br><br>*(Mission-critical task for consultants / experts)* | **Deliverables:**<br>Matrix of successful strategies/ platform<br>Matrices of policy and implementation issues<br>Revised project plan<br>Data summary |
| **Task 4:**<br>Conduct briefing meetings to orient stakeholders, staff, & workgroup participants.<br>• Focus on details of project strategy, tactics, issues.<br>• Gather feedback; solicit concerns & ideas | *Oct '05* | L: Design Director<br><br>C: Operations Director;<br>SPG staff<br><br>SPG staff role = assist in preparing briefing materials (as needed); participate in meetings | People and organizations interested and/or potentially impacted learn about, give input on, and support project | **Deliverables:**<br>Briefing materials |
| **Task 5:**<br>Develop strategy to address data/information gaps identified at Sept "Intensive"; implement strategy | *Oct '05 – Dec '05* | L: SPG Staff<br><br>C: Design Director;<br>Consultants (SPG $$ for consultant time) | Best available data are collected and analyzed to feed into design & decision-making processes | **Deliverables:**<br>Analysis Plan,<br>Summary of findings & implications for design |

| Tasks and Activities | Timetable | Lead (L) / Coordination (C) | Anticipated Results | Evaluation/Measurement |
|---|---|---|---|---|
| **Task 6:**<br>Convene topic-specific workgroup meetings<br>(e.g., benefit design; financing & funding – cost-sharing, premiums, subsidies; reinsurance/risk adjustment; governance; marketing & outreach; operational implementation; monitoring / evaluation)<br><br>Draft legislation (as needed) | *Oct '05 – Dec '05* | L: Design Director<br><br>C: Operations director;<br>Workgroups;<br>SPG staff;<br>Consultants (SPG $$ for consultant time)<br><br>SPG staff role = Participate in and provide tech. asst. to workgroups (e.g., policy input, data support, peer review of proposed direction) | Detailed data and policy analyses complete; preliminary recommendations for program design documented; legislation drafted (if needed) | **Deliverables:**<br>Briefing papers, decision memos<br>Detailed program design (draft)<br>Detailed implementation plan (draft)<br>Draft legislation |
| **Task 7:**<br>"Workgroup Caucus": Bring individual workgroups together for 1-2 day intensive<br>• Consolidate program design features<br>• Identify remaining issues<br>• Confirm implementation plan & schedule<br><br>(outstanding issue = whether consultants / experts attend; related to Task 9 & dollars available) | *Jan '06 – Feb '06* | L: Design Director<br><br>C: Operations director;<br>Workgroups;<br>SPG staff;<br>Consultants (SPG $$ for consultant travel and time)<br><br>SPG staff role = summarize workgroup design recommendations as basis for meeting discussions; facilitate discussion on remaining issues; draft monitoring / evaluation plan | Workgroup analysis and findings aligned; preliminary program design complete and ready for final peer review<br><br>**Major Milestone 1**: This is where "it" happens – all design pieces from various workgroups are put together to create the overall small business assist program design. | **Deliverables:**<br>Preliminary program design document<br>Matrix of outstanding issues<br>Revised implementation plan<br>Draft monitoring and evaluation plan |
| **Task 8:**<br>Report on progress to Administration & Legislature | *Jan '06 – Feb '06* | L: Design Director<br><br>C: SPG staff<br><br>SPG staff role = assist in briefing material preparation; participate in meetings; respond to follow-up questions (as appropriate) | Briefings to Governor's office / Legislature to ensure they are up-to-date and on-board as mid-biennium Legislative session begins | **Deliverables:**<br>Briefing materials;<br>Formal report to Legislature if requested |

| Tasks and Activities | Timetable | Lead (L) / Coordination (C) | Anticipated Results | Evaluation/Measurement |
|---|---|---|---|---|
| **Task 9:**<br>Peer review of program design and implementation plan (national and state experts) | *Feb '06 – Mar '06* | L: Consultants (SPG $$ for consultant time)<br><br>C: Design Director;<br>SPG Staff;<br>Workgroup leads<br><br>SPG staff role: Facilitate peer reviews as needed (e.g., provide additional information); synthesize findings of separate reviews | Necessary changes and remaining decisions clarified and potential impact on project timing known<br><br>*(Mission-critical task for consultants / experts)* | **Deliverables:**<br>Consultants' design reviews and recommendations for refinement |
| **Task 10:**<br>Convene stakeholder meeting(s) – meeting(s) for stakeholders & other interested parties not intimately involved in workgroups | *Mar '06* | L: Design Director<br><br>C: Operations director;<br>SPG staff<br><br>SPG staff role = assist in meeting material preparation; participate; provide tech. asst. in answering questions (as needed) | Stakeholders informed re program design and ready to assist with implementation; last opportunity to affect design (as move into Task 11) | **Deliverables:**<br>Meeting materials |
| **Task 11:**<br>Finalize design;<br>Get final Go / No Go decision;<br>Prepare for procurement | *Feb '06 – Apr '06* | L: Design Director<br><br>C: Decision Makers; Operations director;<br>Operations staff;<br>SPG staff<br><br>SPG staff role = review final design documents; participate in decision meeting, as needed | Small Business Assist Program design is finalized and Go / No Go decision to implement "as is" is made; procurement process designed and in place for Jan 07 start-up.<br><br>**Major Milestone 2**: This is where the decision makers give the final blessing to implement the program as designed. | **Deliverables:**<br>Final program design document(s)<br>Go / No Go decision memo<br>Draft procurement RFP |

| Tasks and Activities | Timetable | Lead (L) / Coordination (C) | Anticipated Results | Evaluation/Measurement |
|---|---|---|---|---|
| **Task 12:**<br>Address all remaining implementation, marketing and outreach, enrollment, and evaluation issues | *May '06 – Jan '07* | L: Operations Director<br><br>C: Design director;<br>Operations staff;<br>SPG staff<br><br>SPG staff role = tech. asst. on monitoring / evaluation issues (through Aug '06) | Operational policies and procedures, contracts, administrative systems changes, training, marketing and outreach; ongoing program monitoring and evaluation tools; and current public program links complete --- program tested and ready to go | **Deliverables:**<br>New and revised computer and administrative systems<br>Marketing materials<br>Final monitoring and evaluation plan |
| **Task 13:**<br>Enrollment and coverage begins | *Jan '07* | L: Operations Director<br><br>C: Operations staff | Small employers and their employees informed and ready to purchase health insurance<br><br>**Major Milestone 3**: Program goes live. | **Deliverables:**<br>Program operational |
| **Goal 2: *Maintain Central Resource re Data & Coverage Strategies*: Estimated budget $40,000, estimated staff - 0.4 FTEs** | | | | |
| **Tasks and Activities** | **Timetable** | **Lead / Coordination** | **Anticipated Results** | **Evaluation/Measurement** |
| **Task 14:**<br>Continue as clearinghouse for data & analyses on Washington's uninsured population.<br>• On-going tech. asst. re correct use of data (e.g., population survey, MEPS)<br>• Ad-hoc data analyses in response to specific questions from stakeholders and new administration (Executive & Legislative)<br>• Self-initiated analyses as tools to prod discussion of issues | *Sep '05*– Aug '06 | L: SPG staff<br><br>C: Relevant state agencies, Governor's Office, Legislative staff, community groups and others with questions & / or sources of information | Policy leaders new to the issues of the uninsured informed; "coverage and uninsured consequences" discussions provoked and supported; efforts to debunk "myths" surrounding the uninsured continued. | **Deliverables**:<br>Documented ad-hoc analyses and technical assistance;<br>Web-site updates<br>Presentations<br>E-mail alerts to stakeholders |

| Tasks and Activities | Timetable | Lead (L) / Coordination (C) | Anticipated Results | Evaluation/Measurement |
|---|---|---|---|---|
| **Task 15:**<br>Continue as clearinghouse for questions on coverage strategies & lessons from national literature, state, & community initiatives. *(This task is the policy analogue to task 14 re data*)<br>• Feedback and input as questions arise from new administration, policy makers & groups re strategies to consider<br>• Analytic support (data, policy, fiscal, implementation issues) re coverage options that have increasing interest e.g., Pay or play policy for larger employers; Covering all children | *Sep '05–*<br>Aug '06 | L: SPG staff<br><br>C: same as Task 14 | Comprehensive and informative policy and data analyses to facilitate and provoke discussions regarding growing gaps in coverage and access, and potential strategies for addressing them (with emphasis on strategies seen as viable by policy makers)<br><br>Bill analyses /recommendations on draft legislation intending to eliminate barriers to coverage and/or affecting public program coverage. | **Deliverables**:<br>Analysis, work products, briefings and presentation materials |
| **Goal 3: *Fulfill HRSA Grantee Commitments*: Estimated budget $19,800, estimated staff - 0.15 FTEs** | | | | |
| **Tasks and Activities** | **Timetable** | **Lead / Coordination** | **Anticipated Results** | **Evaluation/Measurement** |
| **Task 16:**<br>Attend quarterly HRSA meetings (Rotated SPG staff attendance at meetings to ensure adequate mentoring of entire team.) | As determined by HRSA | SPG staff /<br><br>HRSA coordination | Meeting attendance and participation; pre-meeting preparation in anticipation of discussions; inter-state mentoring and access to national experts | **Deliverables**:<br>Participate in agenda planning discussions<br>Presentation/ meeting/ crib-note materials as needed or requested. |
| **Task 17:**<br>Complete report requirements as directed by the HRSA Project Officer, including quarterly and final financial reporting | Sep '05 – Aug '06 (reports as requested)<br><br>Sep '06 (final results report)<br>Nov '06 (final fiscal reports) | SPG staff /<br><br>OFM accounting (financial reports) | Written report documenting project results (linked across initial and all supplemental grants), progress reports as requested, all financial status and other reports as required by Project Officer and grant monitoring offices (completed in formats and per prescribed deadlines). | **Deliverables**:<br>Progress Reports as needed; Final report summarizing planning efforts, results and next steps; Quarterly and final financial reports. |

| Tasks and Activities | Timetable | Lead (L) / Coordination (C) | Anticipated Results | Evaluation/Measurement |
|---|---|---|---|---|
| **Task 18:**<br>Cooperate in the preparation of consolidated national reports and Summary Report to the Secretary | As determined by HRSA | SPG staff /<br><br>HRSA in-house and contracted program staff | Share materials and lessons; provide available data; assist in review of products. | **Deliverables**:<br>Products and input needed by HRSA and their contracted program people to complete consolidated and summary reports. |
| **Task 19:**<br>Be resource to other states and organizations providing assistance to states | As needed | SPG staff | Materials and lessons shared; available data provided; products reviewed as requested. | **Deliverables**:<br>Information and input as needed |
| ***TOTAL PILOT GRANT BUDGET PROPOSAL: Estimated budget* $400,000, estimated staff 2.4 FTEs** | | | | |

**Project Management Plan: Proposed Limited Competition PLANNING Grant Activities (September 2005 – August 2006):**

Differences between the Pilot and Planning proposals are simply a reflection of level of support possible with State Planning Grant funds. Differences are noted below. Otherwise, all aspects of the project management plan are identical for the Pilot and Planning proposals.

**Goal 1: *Small Employer Assist Program*: Estimated budget - $135,200 estimated staff – .65 FTEs (Tasks 2-13)**

- Funding allocated to tasks 2-13 will support approximately 1/3 of the technical assistance provided by SPG staff in the Pilot grant.
- Consultant time for task 5 (filling data gaps) not funded in the Planning grant.
- Consultant time for task 6 (Topic-Specific Workgroups) not funded in the Planning grant.
- Consultant travel and time for task 7 (Workgroup Design Caucus) not funded in the Planning grant.
- Consultant time (122 hours) targeted to task 9 (Design Peer Review) in the Planning grant is approximately 2/3 of consultant expertise available to task 9 in the Pilot grant.

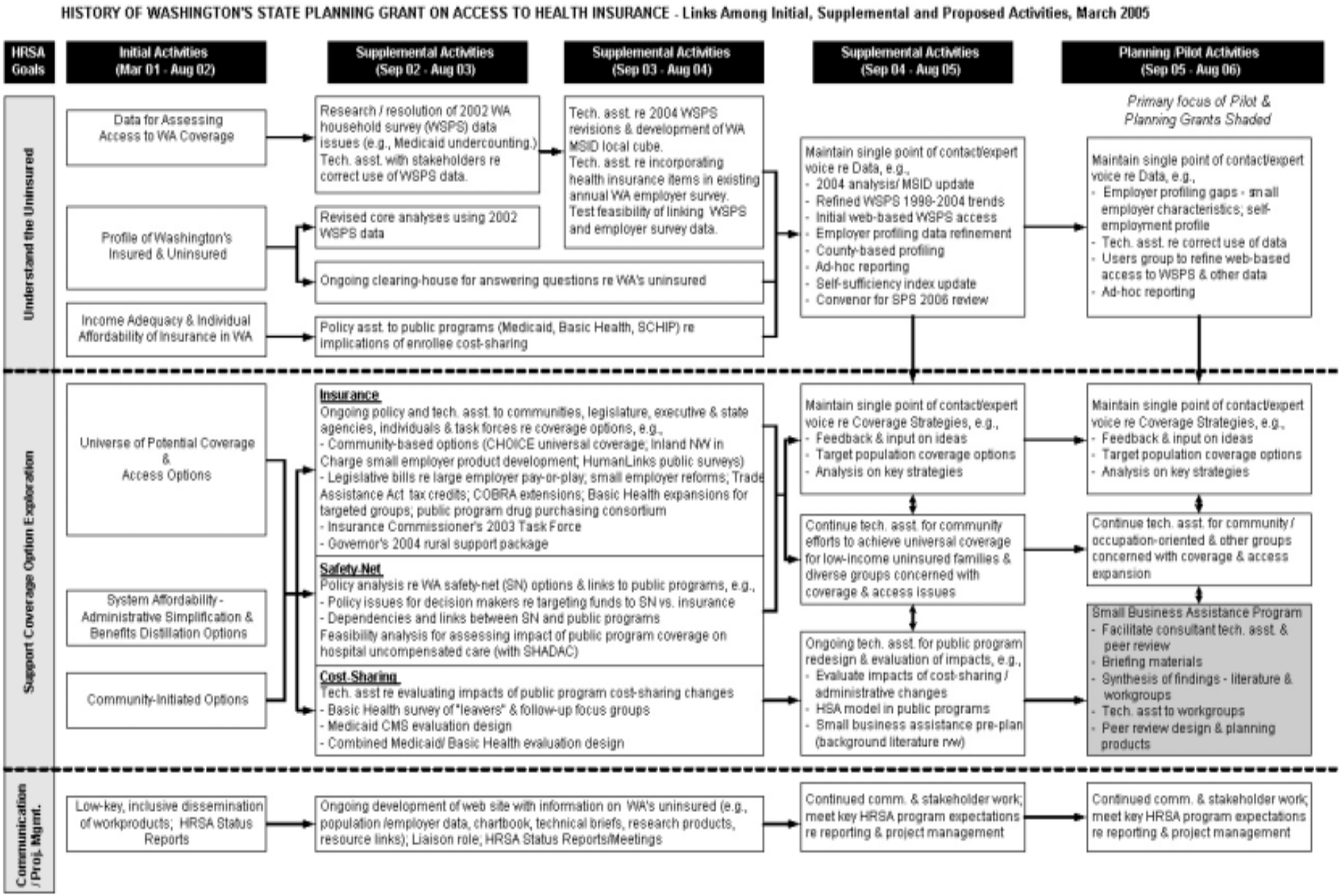
**Goal 2: *Maintain Central Resource re Data and Coverage Strategies*: Estimated budget - $20,000 estimated staff – .2 FTEs**

- SPG Staffing allocated to tasks 14-15 to continue the SPG grant role as a central resource for information on Washington's uninsured and strategies for increasing access to coverage is approximately 50% of staffing for Goal 2 in the Pilot grant.

**Goal 3: *Fulfill HRSA Grantee Commitments*: Estimated budget - $19,800 estimated staff – .15FTEs**

- Consistent with Pilot proposal

***TOTAL PLANNING GRANT BUDGET PROPOSAL: Estimated budget* $175,000, estimated staff 1.0 FTEs**


HISTORY OF WASHINGTON'S STATE PLANNING GRANT ON ACCESS TO HEALTH INSURANCE - Links Among Initial, Supplemental and Proposed Activities, March 2005
HRSA Goals
Initial Activities (Mar 01 - Aug 02)
Supplemental Activities (Sep 02 - Aug 03)
Supplemental Activities (Sep 03 - Aug 04)
Supplemental Activities (Sep 04 - Aug 05)
Planning /Pilot Activities (Sep 05 - Aug 06)
Primary focus of Pilot & Planning Grants Shaded
Understand the Uninsured
Data for Assessing Access to WA Coverage
Research / resolution of 2002 WA household survey (WSPS) data issues (e.g., Medicaid undercounting.) Tech. asst. with stakeholders re correct use of WSPS data.
Tech. asst. re 2004 WSPS revisions & development of WA MSID local cube.
Tech. asst. re incorporating health insurance items in existing annual WA employer survey.
Test feasibility of linking WSPS and employer survey data.
Maintain single point of contact/expert voice re Data, e.g.,
- 2004 analysis/ MSID update
- Refined WSPS 1998-2004 trends
- Initial web-based WSPS access
- Employer profiling data refinement
- County-based profiling
- Ad-hoc reporting
- Self-sufficiency index update
- Convenor for SPS 2006 review
Maintain single point of contact/expert voice re Data, e.g.,
- Employer profiling gaps - small employer characteristics; self-employment profile
- Tech. asst. re correct use of data
- Users group to refine web-based access to WSPS & other data
- Ad-hoc reporting
Profile of Washington's Insured & Uninsured
Revised core analyses using 2002 WSPS data
Ongoing clearing-house for answering questions re WA's uninsured
Income Adequacy & Individual Affordability of Insurance in WA
Policy asst. to public programs (Medicaid, Basic Health, SCHIP) re implications of enrollee cost-sharing
Support Coverage Option Exploration
Universe of Potential Coverage & Access Options
System Affordability - Administrative Simplification & Benefits Distillation Options
Community-Initiated Options
Insurance
Ongoing policy and tech. asst. to communities, legislature, executive & state agencies, individuals & task forces re coverage options, e.g.,
- Community-based options (CHOICE universal coverage; Inland NW in Charge small employer product development; HumanLinks public surveys)
- Legislative bills re large employer pay-or-play; small employer reforms; Trade Assistance Act tax credits; COBRA extensions; Basic Health expansions for targeted groups; public program drug purchasing consortium
- Insurance Commissioner's 2003 Task Force
- Governor's 2004 rural support package
Safety-Net
Policy analysis re WA safety-net (SN) options & links to public programs, e.g.,
- Policy issues for decision makers re targeting funds to SN vs. insurance
- Dependencies and links between SN and public programs
Feasibility analysis for assessing impact of public program coverage on hospital uncompensated care (with SHADAC)
Cost-Sharing
Tech. asst re evaluating impacts of public program cost-sharing changes
- Basic Health survey of "leavers" & follow-up focus groups
- Medicaid CMS evaluation design
- Combined Medicaid/ Basic Health evaluation design
Maintain single point of contact/expert voice re Coverage Strategies, e.g.,
- Feedback & input on ideas
- Target population coverage options
- Analysis on key strategies
Continue tech. asst. for community efforts to achieve universal coverage for low-income uninsured families & diverse groups concerned with coverage & access issues
Ongoing tech. asst. for public program redesign & evaluation of impacts, e.g.,
- Evaluate impacts of cost-sharing / administrative changes
- HSA model in public programs
- Small business assistance pre-plan (background literature rvw)
Maintain single point of contact/expert voice re Coverage Strategies, e.g.,
- Feedback & input on ideas
- Target population coverage options
- Analysis on key strategies
Continue tech. asst. for community / occupation-oriented & other groups concerned with coverage & access expansion
Small Business Assistance Program
- Facilitate consultant tech. asst. & peer review
- Briefing materials
- Synthesis of findings - literature & workgroups
- Tech. asst to workgroups
- Peer review design & planning products
Communication / Proj. Mgmt.
Low-key, inclusive dissemination of workproducts; HRSA Status Reports
Ongoing development of web site with information on WA's uninsured (e.g., population /employer data, chartbook, technical briefs, research products, resource links); Liaison role; HRSA Status Reports/Meetings
Continued comm. & stakeholder work; meet key HRSA program expectations re reporting & project management
Continued comm. & stakeholder work; meet key HRSA program expectations re reporting & project management